ambetter. FROM illinicare health
Insured by Celtic Insurance Company

2019 Evidence of Coverage

Ambetter.IlliniCare.com

Ambetter from IlliniCare Health
EVIDENCE OF COVERAGE
Home Office: 200 East Randolph St, Chicago, IL 60601

Individual Member HMO Contract

In this *contract,* the terms *"you"*, *"your",* or *"yours"* will refer to the *member* or any dependents enrolled in this *contract*. The terms *"we," "our,"* or *"us"* will refer to Ambetter from IlliniCare Health.

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

Annually, *we* must file this product, the *cost share* and the rates associated with it for approval. Guaranteed renewable means that *your* plan will be renewed into the subsequent year's approved product on the anniversary date unless terminated earlier in accordance with *contract* terms. *You* may keep this *contract* (or the new *contract you* are mapped to for the following year) in force by timely payment of the required premiums. In most cases *you* will be moved to a new *contract* each year, however, *we* may decide not to renew the *contract* as of the renewal date if: (1) *we* decide not to renew all contracts issued on this form, with a new *contract* at the same metal level with a similar type and level of benefits, to residents of the state where *you* then live; or (2) we withdraw from the service area or reach demonstrated capacity in a service area; (3) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits.

Annually, *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. *W*e have the right to change premiums after filing and approval by the state.

At least 31 day notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *contract* or a change in a *member's* health. While this *contract* is in force, *we* will not restrict coverage already in force. If *we* discontinue offering and decide not to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where *you* reside, *we* will provide a written notice to *you* at least 90 days prior to the date that *we* discontinue coverage.

This *contract* contains *prior authorization* requirements. *You* may be required to obtain a referral from a *primary care provider* in order to receive care from a specialist provider. Benefits may be reduced or not covered if the requirements are not met. Please refer to the *Schedule of Benefits* and the Prior Authorization Section.

TEN DAY RIGHT TO RETURN CONTRACT

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

Ambetter from IlliniCare Health

Anand Shukla,
SVP, Individual Health – Celtic Insurance Company

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INTRODUCTION

Welcome to Ambetter from IlliniCare Health. We have prepared this *contract* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services.
It describes:

- How to access medical care.
- The healthcare services *we* cover.
- The portion of *your* healthcare costs *you* will be required to pay.

This *contract*, the *Schedule of Benefits*, application, and any amendments or riders attached shall constitute the entire *contract* under which *covered services* and supplies are provided or paid for by *us*.

Because many of the provisions are interrelated, you should read this entire *contract* to gain a full understanding of *your* coverage. Many words used in this *contract* have special meanings when used in a healthcare setting; these words are *italicized* and are defined for *you* in the Definitions section. This *contract* also contains exclusions, so please be sure to read this entire *contract* carefully.

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

How to Contact Us
Ambetter from IlliniCare Health
200 East Randolph St, Chicago, IL 60601

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. CST, Monday through Friday
Member Services **1-855-745-5507**
TTY/TDD line **1-844-517-3431**
Fax **1-855-519-5699**
Emergency **911**
24/7 Nurse Advise Line **1-855-745-5507**

Interpreter Services
Ambetter from IlliniCare Health has a free service to help our *members* who speak languages other than English. This service allows *you* and your *physician* to talk about *your* medical or behavioral health concerns in a way that is most comfortable for *you*.

Our interpreter services are provided at no cost to *you*. We have representatives that speak Spanish and have medical interpreters to assist with languages other than English via phone. *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, please call Member Services at 1-855-745-5507 (TTY/TDD 1-844-517-3431).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting *you* as a *member*.
2. Encouraging open discussions between *you, your physician* and *medical practitioners*.
3. Providing information to help *you* become an informed health care consumer.
4. Providing access to *covered services* and *our network providers*.
5. Sharing *our* expectations of *you* as a *member*.

You have the right to:

1. Participate with *your physician* and *medical practitioners* in 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 performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our network* of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from *your primary care provider* about what might be wrong (to the level known), treatment and any known likely results. *Your primary care provider* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your 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 provider* assignment, providers, advance directive information, referrals and *authorizations*, benefit denials, *member* rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such notices shall include the following:
    a. Any changes in clinical review criteria
    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, ethnicity, race, gender, sex, sexual orientation, disability, 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 provider*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care provider*. *Your primary care provider* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
19. Select *your primary care provider* within the *network*. *You* also have the right to change your *primary care provider* or request information on *network providers* close to your home or work.
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 provider*.
21. An interpreter when *you* do not speak or understand the language of the area.
22. A second opinion by a *network provider*, if *you* want more information about *your* treatment or would like to explore additional treatment options.
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 provider* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
    a. Living Will.
    b. Health Care Power of Attorney.
    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 entire *contract.*
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of your *physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* ID card and keep scheduled appointments with *your physician*, and call the *physician*'s office during office hours whenever possible if *you* have a delay or cancellation.
6. Know the name of *your* assigned *primary care provider*. *You* should establish a relationship with *your physician*. *You* may change your *primary care provider* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* 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 provider* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think *you* have a medical *emergency*. For all other care, *you* should call *your primary care provider*.
14. When *you* enroll in this coverage, give all information about any other medical coverage *you* have. If, at any time, *you* get other medical coverage besides this coverage, *you* must tell the entity with which *you* enrolled.
15. Pay *your* monthly premium on time and pay all *deductible amounts, copayment amounts*, or *cost-sharing* percentages at the time of service.

Your Provider Directory

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

At any time, *you* can request a copy of the provider directory at no charge by calling Member Services at 1-855-745-5507 (TTY/TDD 1-844-517-3431). In order to obtain benefits, *you* must designate a *network primary care provider* for each *member.* *We* can help *you* pick a *primary care provider* (PCP). *We* can make your choice of *primary care provider* effective on the next business day.

Call the *primary care provider*'s office if *you* want to make an appointment. If *you* need help, call Member Services at 1-855-745-5507 (TTY/TDD 1-844-517-3431). *We* will help *you* make the appointment.

Your Member ID Card

When *you* enroll, *we* will mail you a *member* ID card after *we* receive *your* enrollment materials, which includes receipt of your initial premium payment. This card is proof that *you* are enrolled in an Ambetter plan from IlliniCare Health. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under the *contract*.

The ID card will show *your* name, *member* ID#, and *copayment amounts* required at the time of service. If *you* do not get *your* ID card within a few weeks after *you* enroll, please call Member Services at 1-855-745-5507 (TTY/TDD 1-844-517-3431), twenty-four hours per day, seven days a week. *We* will send *you* another card.

Our Website

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

1. Finding a *network provider*.
2. 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. Selecting a primary care provider.
5. *Deductible* and *co-payment* accumulators.
6. Our formulary or preferred drug list.
7. Member Rights and Responsibilities.
8. Notice of Privacy.
9. Current events and news.

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

Quality Improvement

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

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

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

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

DEFINITIONS

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

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

Adverse benefit determination means 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 Claims and Appeals Procedures and External Review section of this *contract* for information on *your* right to appeal an *adverse benefit determination.*

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

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

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

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

Applied behavior analysis is endorsed by the US Surgeon General, The American Academy of Pediatrics and National Institutes of Child Health and Human Development. This scientifically proven treatment is intensive and individualized therapy useful for gains in all developmental areas including social, language, and behavioral.

Attending physician means the physician responsible for the care of a patient and/or the physician supervising the care of patients by residents, and /or medical students.

Authorization or ***Authorized*** (also "Prior Authorization" or "Approval") means our decision to approve the medical necessity or the appropriateness of care for a *member* by the *member's PCP* or *provider* group.

Authorized Representative means an individual who represents a covered person in an internal appeal or external review process of an adverse benefit determination who is any of the following:

- A person to whom a covered individual has given express, written consent to represent that individual in an internal appeal process or external review process of an adverse benefit determination;
- A person authorized by law to provide substituted consent for a covered individual; or
- A family member or a treating health care professional, but only when the covered person is unable to provide consent.

Autism spectrum disorder refers to a group of complex disorders represented by repetitive and characteristic patterns of behavior and difficulties with social communication and interaction. The symptoms are present from early childhood and affect daily functioning as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases.

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.

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.

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

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

Center of Excellence means a *hospital* that:

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

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

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

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

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

Complications of pregnancy means:

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

Contract when *italicized,* refers to this *contract,* as 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.

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 reductions lower the amount *you* have to pay in *deductibles*, *copayments* and *coinsurance*. To qualify for *cost-sharing reductions*, an eligible individual must enroll in a silver level plan through the Marketplace or be a member of a federally recognized American Indian tribe and/or an Alaskan Native enrolled in a QHP through the Marketplace.

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

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

Custodial care is treatment designed to assist a *member* with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily injury.

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

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

Deductible amount 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.

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

Dependent member means *your spouse, civil union partner* or an *eligible child*.

Drug Discount, Coupon, or Copay Card means cards or coupons typically provided by a drug manufacturer to discount the copay or your other out of pocket costs (e.g. deductible or maximum out of pocket).

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 date a *member* becomes covered under this *contract* for covered services.

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

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

e. The patient's *primary care provider*, if any, is involved in the coordination of care

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

1. A natural child;
2. A legally adopted child;
3. A stepchild;
4. A child placed with *you* for adoption;
5. A child for whom legal guardianship has been awarded to *you* or *your spouse*. It is *your* responsibility to notify the entity with which *you* enrolled (either the Marketplace or *us*) if *your* child ceases to be an *eligible child*. *You* must reimburse *us* for any benefits that *we* provide or pay for a child at a time when the child did not qualify as an *eligible child*;
6. A child who is in your custody, pursuant to an interim court order of adoption; or
7. A foster child regardless of whether the child is residing with the *member*.

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

1. is an Illinois resident;
2. served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States; and
3. has received a release or discharge other than a dishonorable discharge.

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

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

1. For *network providers:* When a *covered service* is received from a *network provider*, the *eligible service expense* is the contracted fee with that provider.
2. For *non-network providers*:
    a. When a *covered service* is received from a *non-network provider* as a result of an *emergency*, the *eligible service expense* is the 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). Emergency care received from a *non-network provider* will be paid at no greater out-of-pocket to the *member* than had a *network provider* been utilized. However, if the provider has not agreed to accept a negotiated fee as payment in full, the *eligible service expense* is the greatest of the following (*you* will not be *balance billed* by the provider, if *you* are, please contact Member Services):
        i. the amount that would be paid under Medicare,
        ii. the amount for the *covered service* calculated using the same method we generally use to determine payments for out-of-network services, or
        iii. the contracted amount paid to *network providers* for the *covered service*. If there is more than one contract amount with *network providers* for the *covered service*, the amount is the median of these amounts.
    b. When a *covered service* is received from a *non-network provider* as approved or authorized by *us* that is not the result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the provider as payment in full (you will not be billed for the difference between the negotiated fee and the provider's charge). If there is no negotiated fee agreed to by the provider with *us*, the *eligible service expense* is the amount that would be paid under Medicare (*you* will not be balance billed by the provider, if *you* are, please contact Member Services).
    c. When a *covered service* is received from a *non-network provider* upon referral by *your primary care provider* because the service or supply is not of a type provided by any *network provider* and is needed for ongoing care to treat a specific condition, the *eligible service expense* is the

lesser of (1) the negotiated fee, if any, that has been mutually agreed upon by *us* and the provider as payment in full; or (2) the amount accepted by the provider (not to exceed the provider's charge).

Emergency means a medical condition manifesting itself by such acute symptoms of sufficient severity including, but not limited to, severe pain, that a prudent layperson with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

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

Essential Health Benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, *emergency services*, *hospitalization*, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. *Essential Health Benefits* provided within this contract are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime or annual dollar maximum.

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

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

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

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

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

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

Extended care facility does not include a facility primarily for rest, the aged, *custodial care,* or nursing care.

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

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

Grievance means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing in any form to the insurer by, or on behalf of, a *member* including any of the following:
1. Provision of services;
2. Determination to rescind a contract;
3. Determination of a diagnosis or level of service required for evidence-based treatment of *autism spectrum disorders*; and
4. Claims practices.

Habilitation 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.

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

Home health care means care or treatment of an *illness* or *injury* at the *member's* home that is:
1. Provided by a *home health care agency*; and
2. Prescribed and supervised by a *physician*.

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

An agency that is approved to provide *home health care* to those receiving Medicare benefits will be deemed to be a *home health care agency*.

Hospice means an institution that:

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

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

Hospital means an institution that:

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

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

Iatrogenic infertility means impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

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

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

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

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

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

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

Intensive care unit means a Cardiac Care Unit, or other unit or area of a *hospital* that meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Intensive day rehabilitation means two or more different types of therapy provided by one or more *rehabilitation licensed practitioners* and performed for three or more hours per day, five to seven days per week.

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

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

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

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

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a *service area*, loss of coverage because an individual no longer resides or lives 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 or lives in the *service area* (whether or not within the choice of the individual), and no other benefit package is available to the individual;
4. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in 26 CFR § 54.9802-1(d)) that includes the individual;
5. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent;
6. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

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

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

Maximum out-of-pocket amount is the sum of the *deductible amount*, *prescription drug deductible amount* (if applicable), *copayment amount* and *coinsurance* percentage of *covered expenses*, as shown in the *Schedule of Benefits*. After the *maximum out-of-pocket amount* is met for an individual, Ambetter pays 100% of *eligible service expenses* for that individual. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket amount*. 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 service 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.

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

Maximum therapeutic benefit means the point in the course of treatment where no further improvement in a *covered person's* medical condition can be expected, even though there may be fluctuations in levels of pain and function.

Medical practitioner* or *other practitioner includes but is not limited to a *physician*, advanced practice nurse, *licensed mental health professional*, nurse anesthetist, physician's assistant, physical therapist, midwife, *rehabilitation licensed practitioner*, or registered surgical assistant. The following are examples of providers that are NOT *medical practitioners*, by definition of the *contract:* acupuncturist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, *emergency* medical technician, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. Is provided in the most cost effective care facility or setting;

7. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; and
8. When specifically applied to a *hospital* confinement, it means that the diagnosis and treatment of *your* medical symptoms or conditions cannot be safely provided as an outpatient.

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

Medically necessary medical supplies mean medical supplies that are:
1. *Medically necessary* to the care or treatment of an *injury* or *illness*;
2. Not reusable or *durable medical equipment*; and
3. Not able to be used by others.

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

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

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

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

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

Mental health disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions. It includes, but is not limited to: schizophrenia, paranoid and other psychotic disorders, bipolar disorders (hypomanic, manic, depressive and mixed), major depressive disorders (single episode or recurrent), schizoaffective disorders (bipolar or depressive), pervasive developmental disorders, obsessive-compulsive disorders, depression in childhood and adolescence, panic disorder, post-traumatic stress disorders (acute, chronic, or with delayed onset), anorexia nervosa, bulimia nervosa or conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and the most recent edition of the International Classification of Diseases.

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

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

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

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

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

Orthotic Device means a medically necessary device used to support, align, prevent or correct deformities, protect a body function, improve the function and moveable body part or assist with dysfunctional joints. Orthotics must be used to for therapeutic support, protection, restoration or function of an impaired body part for treatment of an illness or injury.

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 services include facility, ancillary, and professional charges when given as an outpatient at a *hospital,* alternative care facility, retail health clinic, or other provider as determined by the plan. These facilities may include a non-hospital site providing diagnostic and therapy services, surgery, or *rehabilitation*, or other provider facility as determined by *us*. Professional charges only include services billed by a *physician* or other professional.

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

Period of extended loss means a period of consecutive days:

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

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

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

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

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

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

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

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

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

Primary care provider (PCP) means a *provider* who gives or directs health care services for *you*. PCPs include internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), Physician Assistants (PA), obstetrician gynecologist (ob-gyn) and pediatricians or any other practice allowed by the Plan. A PCP supervises, directs and gives initial care and basic medical services to *you* and is in charge of *your* ongoing care.

Prior Authorization means a decision to approve specialty or other *medically necessary* care for a *member* by the *member's* PCP or provider group to the *member* prior to rendering services.

Proof of loss means information required by *us* to decide if a claim is payable and the amount that is payable. It may include, but is not limited to, claim forms, medical bills or records, other plan information, payment of claim 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 a medically necessary device used to replace, correct, or support a missing portion of the body, to prevent or correct a physical deformity or malfunction, or to support a weak or deformed portion of the body.

Qualified health plan or ***QHP*** means a health plan that has in effect a certification that it meets the standards issued or recognized by each Health Insurance Marketplace through which such plan is offered.

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

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

Rehabilitation means care for restoration (including by education or training) of one's prior ability to function at a level of *maximum therapeutic benefit*. This includes *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,* or nursing care.

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

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

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

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

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

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

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

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*.

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

Specialist physician means a *physician* who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Spouse means the person to whom *you* are lawfully married or, if you are a party to a *civil union* under the Illinois Religious Freedom Protection and Civil Union Act, the other party to such *civil union*.

Standard fertility preservation services means procedures based upon current evidence-based standard of care established by the American Society of Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

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

Substance use disorder means alcohol, drug or chemical abuse, overuse, or dependency. Covered *substance use disorders* are those listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and the most recent edition of the International Classification of Diseases.

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.

Telehealth services means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the *provider* for telehealth is at a distant site. Telehealth services include synchronous interactions and asynchronous store and forward transfers.

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

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

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

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

Unproven service(s) means services, including medications that are determined not to be effective for treatment of the medical condition, or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from *well-conducted randomized controlled trials* or *well-conducted cohort studies* in the prevailing published peer-reviewed medical literature.
1. *"Well-conducted randomized controlled trials"* means that two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.
2. *"Well-conducted cohort studies"* means patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

Urgent care center means a facility, not including a *hospital emergency* room or a *physician's* office, that provides treatment or services that are required:
1. To prevent serious deterioration of a *member's* health; and
2. As a result of an unforeseen *illness, injury,* or the onset of acute or severe symptoms.

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

DEPENDENT MEMBER COVERAGE

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

1. The date *you* became covered under this *contract;* or
2. The date of a newborns birth; or
3. The date that an adopted child is placed with the subscriber for the purposes of adoption, when an *eligible child* is placed in the custody of *you* and *your spouse* pursuant to an interim court order of adoption vesting temporary care of the child to you or your spouse, regardless of whether a final order granting adoption is ultimately issued or the subscriber assumes total or partial financial support of the child.

Effective Date For Initial Dependent Members
The *effective date* for *your* initial *dependent members,* will be the same date as *your* initial coverage date. Only *dependent members* included in the application for this *contract* will be covered on *your effective date*.

Coverage for a Newborn Child
An *eligible child* born to *you* or a family *member* will be covered from the time of birth until the 31st day after its birth.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth. Notice of the newborn must be given to *us* within 31 days after the date of birth in order to have the coverage continue after the 31 day period and will require payment of the additional premium. If notice is not given within the 31 days from birth, *we* will charge an additional premium from the date of birth. If notice is given by the Health Insurance 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 from the entity that *you* have enrolled with (either the Marketplace or *us*).

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

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

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

As used in this provision, *"placement"* means the assumption and retention by you or your spouse for total or partial support of the child in anticipation of the adoption of the child. . Placement includes when an eligible child is placed in the custody of you or your spouse pursuant to an interim court order of adoption vesting temporary care of the child in *you* or *your spouse*, regardless of whether a final order granting adoption is ultimately issued.

Adding Other Dependent Members
If *you* are enrolled in an off-exchange policy and apply in writing to add a *dependent member* 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.

Prior Coverage
If a *member* is confined as an inpatient in a hospital on the effective date of this agreement, and prior coverage terminating immediately before the effective date of this agreement furnishes benefits for the hospitalization after the termination of prior coverage, then services and benefits will not be covered under this agreement for that member until the *member* is discharged from the hospital or benefits under the prior coverage are exhausted, whichever is earlier.

ONGOING ELIGIBILITY

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

1. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *contract* or the date that we have not received timely premium payments in accordance with the terms of this *contract*; or
2. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or
3. The date the primary *member* no longer resides or lives in the *service area* of this plan; or
4. The date *we* decline to renew this *contract*, as stated in the discontinuance provision; or
5. The date of a covered person's death.
6. The date of termination that the Marketplace provides *us* upon *your* request of cancellation to the Marketplace, or if *you* enrolled directly with *us*, the date *we* receive a request from *you* to terminate this *contract*, or any later date stated in *your* request.

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

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

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

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

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

Open Enrollment
There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 1, 2018 and extends through December 15, 2018. *Qualified individuals* who enroll on or before December 15, 2018 will have an *effective date* of coverage on January 1, 2019.
The Health Insurance Marketplace may provide a coverage *effective date* for a *qualified individual* earlier than specified in the paragraphs above, provided that either:

1. The *Qualified individual* has not been determined eligible for *advanced payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *Qualified individual* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of *advanced payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month. *We* will send written annual open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

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

1. A *qualified individual* or *dependent loses minimum essential coverage*; or
2. A *qualified individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption or placement for adoption; or
3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status; or
4. A *qualified* individual's enrollment or non-enrollment in a *qualified health plan* is unintentional, inadvertent, or erroneous and is the result of the error, intentional misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace or HHS, or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, intentional misrepresentation, or inaction; or
5. An enrollee adequately demonstrates to the Health Insurance Marketplace that the *qualified health plan* in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee; or
6. An individual is determined newly eligible or newly ineligible for *advanced payments of the premium tax credit* or has a chance in eligibility for *cost-sharing reductions*, regardless of whether such individual is already enrolled in a *qualified* health plan; or
7. A *qualified individual* or enrollee gains access to new qualified health plans as a result of a permanent move; or
8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended; or
9. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a *qualified health plan* or change from one *qualified health plan* to another one time per month; or
10. A *qualified individual* or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide.

Coverage for a special enrollment request that *we* receive between the 1st and 15th of any month will become effective on the 1st day of the following month. Coverage for a special enrollment request received between the 16th and last day of any month will become effective on the 1st day of the second following month.

Coverage for a special enrollment request as a result of birth, adoption, placement for adoption, placement in foster care will be effective on the date of the occurrence or the 1st of the month following the occurrence.

Coverage for a special enrollment request as a result of marriage will be effective on the 1st day of the month following plan selection.

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 31 days of the grace period, if *advanced premium tax credits* are received.

We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first 31 days of the grace period, and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. *We* will notify HHS of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the second and third month of the grace period. *We* will continue to collect *advanced premium tax credits* on behalf of the *member* from the Department of the Treasury, and will return the *advanced premium tax credits* on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above.

When a member is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 31 day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *contract* will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. *We* will notify HHS, as necessary, of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the grace period.

Third Party Payment
We will accept payments on the *member's* behalf from the following *third party* payers:
1. Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
2. Indian tribes, tribal organizations or urban Indian organizations;
3. State and Federal Government programs;
4. Private, not-for-profit foundations which have no incentive for financial gain, no financial relationship, or affiliation with *providers* of *covered services* and supplies on behalf of *members*, where eligibility is determined based on defined criteria without regard to health status and where payments are made in advance for a coverage period from the effective date of eligibility through the remainder of the calendar year; or
5. Family members

Misstatement of Age
If a *member's* age has been misstated, the *member's* premium may be adjusted to what it should have been, based on the *member's* actual age.

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

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

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

COST SHARING FEATURES

Cost Sharing Features
We will pay benefits for *covered services* as described in the *Schedule of Benefits* and the covered services sections of this *contract*. All benefits we pay will be subject to all conditions, limitations, and *cost sharing* features of the *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
Members may be required to pay *copayment* at this 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 *maximum out-of-pocket* 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 each/all *members* before any benefits are provided or payable. 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 provided or payable will be subject to:
1. Any specific benefit limits stated in the *contract*; and
2. A determination of *eligible service expenses.*

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

Note: Except for services or supplies provided for an emergency or by a *non-network provider* when no *network provider* is available and when authorized by us, the bill *you* receive for services or supplies from a *non-network provider* may be significantly higher than the *eligible service expenses* for those services or supplies. In addition to the *deductible amount*, *copayment amount*, and *cost sharing* percentage, *you* may be responsible for the difference between the *eligible service expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible service expense* will not apply to *your deductible amount* or *maximum out-of-pocket*.

ACCESS TO CARE

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

Your network primary care provider will be responsible for coordinating all *covered services* with other *network providers. You* do not need a referral from *your network primary care provider* for mental or behavioral health services, 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.

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

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

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

MEDICAL SERVICE BENEFITS

The plan provides coverage for healthcare services for a *member* or covered dependent. Some services require *prior authorization*. *Copayment amounts* must be paid to *your network provider* at the time *you* receive services. All *covered services* are subject to conditions, exclusions, limitations, terms and provisions of this *contract*. *Covered service*s must be *medically necessary* and not *experimental or investigational*.

Benefit Limitations
Limitations may also apply to some *covered services* that fall under more than one *covered service* category. Please review all limits carefully. Ambetter will not pay benefits for any of the services, treatments, items or supplies that exceed benefit limits.

Ambulance Service Benefits
Covered service expenses will include ambulance services for local transportation:

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

Exclusions:
No benefits will be paid for:

1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-*emergency* air ambulance.
3. Air ambulance:
    a. Outside of the 50 United States and the District of Columbia;
    b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
    c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States.
4. Ambulance services provided for a *member's* comfort or convenience.
5. Non-emergency transportation excluding ambulances.

Mental Health and Substance Use (including Alcoholism) Disorder Benefits
The coverage described below is intended to comply with requirements under the Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Mental health services will be provided on an *inpatient* and *outpatient* basis and include treatable mental health conditions. These conditions affect the individual'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 *network*. *Deductible* amounts, *copayment* or *coinsurance* amounts and treatment limits for covered *mental health* and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

Covered services for mental health and *substance use disorder* are included on a non-discriminatory basis for all

members for the diagnosis and *medically necessary* and active treatment of mental, emotional, and/or *substance use disorders* as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association or the International Statistical Classification of Diseases and Related Health Problems (ICD).

When making coverage determinations, *our* utilization management staff employ 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. They utilize McKesson's Interqual criteria for mental health determinations and American Society of Addiction Medicine (ASAM) criteria for *substance use disorder* determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

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

Inpatient

1. Inpatient psychiatric hospitalization;
2. Inpatient detoxification treatment;
3. Inpatient Rehabilitation
4. Observation;
5. Crisis stabilization;
6. Residential treatment facility for mental health and *substance use*; and
7. Electroconvulsive therapy (ECT).

Outpatient

1. Partial Hospitalization Program (PHP);
2. Intensive Outpatient Program (IOP);
3. Mental health day treatment.
4. Outpatient detoxification programs;
5. Evaluation and assessment for mental health and substance use;
6. Individual and group mental health evaluation and treatment;
7. Medication Assisted Treatment – combines behavioral therapy and medications to treat *substance use disorders*;
8. Medication management services;
9. Psychological and neuropsychological testing and assessment;
10. Applied Behavior Analysis for treatment of autism;
11. Telehealth; and
12. Electroconvulsive Therapy (ECT).

Behavioral health covered services are only for the diagnosis or treatment of mental health conditions and the treatment of substance use/chemical dependency.

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

Habilitation Expense Benefits

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

a. Out-patient physical *rehabilitation* services including speech and language therapy and/or occupational therapy, performed by a licensed therapist.
b. Clinical therapeutic intervention defined as therapies supported by empirical evidence, which include but are not limited to applied behavioral analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform

the services in accordance with a treatment plan.

c. Mental/behavioral health outpatient services performed by a licensed psychologist, psychiatrist, or *physician* to provide consultation, assessment, development and oversight of treatment plans.

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

Autism Spectrum Disorder Expense Benefit

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

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. Coverage of *autism spectrum disorders* will include applied behavior analysis that is intended to develop, maintain, and restore the functioning of an individual.
4. Coverage of *autism spectrum disorder* will include therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:
    a. Self-care and feeding.
    b. Pragmatic, receptive, and expressive language.
    c. Cognitive functioning.
    d. Applied behavior analysis, intervention and modification.
    e. Motor planning.
    f. Sensory processing.

Home Health Care Service Expense Benefits

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

1. *Home health aide services*.
2. Services of a private duty registered nurse rendered on an outpatient basis.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
4. I.V. medication and pain medication to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Medically necessary medical supplies*.
7. Hospital laboratory services to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.
8. Rental or purchase of *medically necessary durable medical equipment* at the discretion of the plan. 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.
9. Sleep study.

At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase.

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

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

Hospice Care Service Expense Benefits
Hospice care benefits are allowed for a *member* that has a terminal illness with a life expectancy of one year or less, as certified by your *attending physician*, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Covered services include:

1. Room and board in a *hospice* while the *member* is an *inpatient.*
2. Coordinated Home Care*.*
3. Medical supplies and dressings.
4. Medications.
5. Skilled and non-skilled nursing services.
6. Physical and occupational therapy.
7. Speech-language therapy.
8. *Physician* visits.
9. The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *contract* if the *member* had been confined in a *hospital.*
10. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
11. Counseling the *member* regarding his or her *terminal illness.*
12. *Terminal illness counseling* of the *member's immediate family.*
13. *Bereavement counseling*.
14. Social and spiritual services.
15. Respite Care Services.

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

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

In accordance with the terms of this contract, up to 60 treatments per year of outpatient rehabilitative therapy and cardiac rehabilitative therapy that is medically necessary and authorized by us will be covered for conditions that are expected to result in significant improvement within two months as determined by your *primary care provider*. The 60 treatments per year for Outpatient Rehabilitative Therapy consists of 20 visits per therapy (PT, OT, ST).

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

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

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

Respite Care *Expense Benefits*

Respite care is covered on an inpatien*t* or outpatient basis to allow temporary relief to family *members* from the duties of caring for a covered person under *hospice* care. Respite days that are applied toward the *deductible amount* are considered benefits provided and shall apply against any maximum benefit limit for these services.

Medical Foods

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

Chiropractic and Osteopathic Services

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

Hospital Benefits

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

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

Emergency treatment of an *injury* or *illness*, even if confinement is not required. See your *Schedule of Benefits* for limitations.

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. Made by a *physician* for professional services, including *surgery.*
3. Made by an assistant surgeon.
4. For the professional services of a *medical practitioner.*
5. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
6. For diagnostic testing using radiologic, ultrasonographic, or laboratory services.
7. For chemotherapy and radiation therapy or treatment.
8. For the cost and administration of an anesthetic.
9. For oxygen and its administration.
10. For *dental service expenses* related specifically and directly to a medical condition.
11. For *dental service expenses* when a *member* suffers an *injury,* after the *member's effective date* of coverage, that results in:
    a. Accidental damage to his or her natural teeth; and

b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any *injury* as a result of chewing.

12. Oral surgery/TMJ services and devices, limited to:
    a. surgical removal of complete bony impacted teeth;
    b. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
    c. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
    d. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.
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. Coverage will include: *inpatient* treatment following mastectomy for length of time to be determined by *attending physician*; and availability of post-discharge physician office visit or in-home nurse visit within 48 hours of discharge. Coverage includes all *medically necessary* pain medication and pain therapy related to the treatment of breast cancer. As used here, "pain therapy" means pain therapy that is medically based and includes reasonably defined goals, including, but not limited to, stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals.
14. For *medically necessary* services and supplies used in the treatment of diabetes*. Covered service expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; insulin pumps; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.
15. For the following types of tissue transplants:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.
    e. Implantable prosthetic lenses, in connection with cataracts.
16. Family planning for certain professional provider contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices. Medical history review, physical examinations, laboratory tests related to physical examinations, contraceptive counseling and all FDA-approved contraception methods are covered without *cost sharing*. This benefit contains both pharmaceutical and medical methods, including: intrauterine devices (IUD), including insertion and removal; barrier methods including: condoms (Rx required from provider, limited to 30 per month), diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide and spermicide alone; oral contraceptives including the pill (combined pill and extended/continuous use), and the mini pill (Progestin only), patch; other hormonal contraceptives, including inserted and implanted contraceptive devices, hormone contraceptive injections and the vaginal contraceptive ring; emergency contraception (the morning after pill).
17. Allergy testing, injections and serum.
18. X-ray and other radiology services.
19. Magnetic Resonance Imaging (MRI).
20. CAT scans.
21. Positron emission tomography (PET scanning).
22. Coverage for a complete and thorough clinical breast examination for the purpose of early detection and prevention of breast cancer at the following intervals:

a. At least every 3 years for *members* 20 years of age and under 40 years of age; and
b. Annually for *members* 40 years of age or older.

Coverage include services provided by a *physician,* an advanced practice nurse who has a collaborative agreement with a collaborating *physician* that authorizes breast examinations or a physician assistant who has been delegated authority to provide breast examinations.

23. Dental anesthesia charges incurred, in conjunction with dental care that is provided to a *member* in a *hospital* or an *ambulatory care facility* if any of the following applies:
    a. the *member* is a child age 6 or under;
    b. the *insured person* has a medical condition that requires hospitalization or general anesthesia for dental care; or
    c. the *member* is disabled.

    Disabled means a *member*, regardless of age, with a chronic disability if the chronic disability meets all of the following conditions. It is attributable to a mental or physical impairment or combination of mental and physical impairments:
    a. It is likely to continue;
    b. It results in substantial functional limitations in one or more of the following areas of major life activity:
        - self-care;
        - receptive and expressive language;
        - learning;
        - mobility;
        - capacity for independent living; or
        - economic self-sufficiency.
24. Following a recommendation for elective surgery. Coverage will be provided at 100% of claim charge for one consultation and related diagnostic service by a *physician*. If requested, benefits will be provided for an additional consultation when the need for surgery, in your opinion, is not resolved by the first consultation.
25. Coverage for outpatient end stage renal disease treatment including both outpatient and in-patient settings based on medical necessity,
26. Coverage for any *emergency*, other medical or hospital expense, if *member* is intoxicated or under the influence of any narcotic, regardless of whether the intoxicant or narcotic is administered on the advice of a health care practitioner.
27. Coverage for routine physical examinations for expenses incurred in the examination and testing of a victim of a criminal sexual assault or abuse from a *network provider* or *non-network provider*. No cost sharing will apply.
28. Annual digital rectal examination and prostate-specific antigen test for males upon recommendation of physician. Must include asymptomatic *members* age 50 and over; African-American *members* age 40 and over; and *members* age 40 and over with family history of prostate cancer.
29. *Medically necessary* treatment for varicose and spider veins treatment.
30. Bariatric surgery.
31. For naprapathic services. See the *Schedule of Benefits* for benefit levels or additional limits.
32. Preventive services for the treatment of obesity.
33. Coverage for *durable medical equipment.*
34. For *medically necessary* genetic blood tests.
35. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
36. For *medically necessary* telemedicine.
37. Preadmission testing.
38. Coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome, including, but not limited to, the use of intravenous immunoglobulin therapy.

Fertility Preservation Services
Coverage for *medically necessary* expenses for *standard fertility preservation services* when a necessary medical treatment may directly or indirectly cause *iatrogenic infertility* to a *member*.

Infertility Expense Benefits
Infertility coverage for the diagnosis and treatment of infertility including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, oocyte retrieval and intracytoplasmic sperm injection.

Coverage for procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer shall be required only if:

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

Dialysis Services
We cover *medically necessary* acute and chronic dialysis service. Covered expenses include:
- Services provided in an Outpatient Dialysis Facility or when services are provided in the Home;
- Processing and administration of blood or blood components;
- Dialysis services provided in a Hospital;
- Dialysis treatment of an acute or chronic kidney ailment which may include the supportive use an artificial kidney machine.

After *you* receive appropriate training at a dialysis facility *we* designate, *we* also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We will determine if equipment is made available on a rental or purchase basis. 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.

Diabetes Management Services
Covered expenses for the nutritional, educational, and psychosocial treatment of a qualified *member*. Such Diabetes Management Services/Diabetes Self—Management Training for which a physician or other participating provider has written an order to the member, and is limited under the direction of a Participating Physician.

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.

Durable medical equipment
The rental (or, at *our* option, the purchase) of durable medical equipment prescribed by a *physician* or other provider. *Durable medical equipment* is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are *covered services*. Payment for related supplies is a *covered service* only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the *member*; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered services may include, but are not limited to:
1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for IV fluids and medicine.
5. Glucometer.
6. Tracheotomy tube.
7. Cardiac, neonatal and sleep apnea monitors.
8. Augmentive communication devices are covered when we approve based on the *member's* condition.

Exclusions:
Non-covered items may include but are not limited to:
1. Air conditioners.
2. Ice bags/coldpack pump.
3. Raised toilet seats.
4. Rental of equipment if the *member* is in a facility that is expected to provide such equipment.
5. Translift chairs.
6. Treadmill exerciser.
7. Tub chair used in shower.

Medical and surgical supplies
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. Med-injectors.
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.

Health Management Programs Offered
Ambetter from IlliniCare Health offers the following health management programs:
1. Asthma;
2. Coronary Artery Disease;
3. Diabetes (adult and pediatric);
4. Hypertension;
5. Hyperlipidemia;
6. Low Back Pain; and
7. Tobacco Cessation

To inquire about these programs or other programs available, you may visit our website at Ambetter.IlliniCare.com or by contacting Member Services at 1-855-745-5507 (TTY/TDD 1-844-517-3431).

Outpatient Medical Supplies Expense Benefits

Covered expenses for outpatient medical supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs (but not the replacement thereof, unless required by a physical change in the *covered person* and the item cannot be modified). If more than one prosthetic device can meet a *covered person's* functional needs, only the charge for the most cost effective prosthetic device will be considered a *covered expense*.
2. For one pair of foot orthotics per year per *covered person*.
3. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
4. For rental of *medically necessary durable medical equipment*.
5. For the rental of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery.
6. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns.
7. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery. See the *Schedule of Benefits* for benefit levels or additional limits.
8. *Medically necessary* amino acid-based elemental formula for the diagnosis and treatment of (i) eosinophilic disorders and (ii) short bowel syndrome when prescribed by a *physician*.
9. Contraceptive coverage for a *member* and any *dependent* for all FDA-approved contraception methods are approved for *members* without *cost sharing* as required under the *Affordable Care Act*. *Members* have access to the methods available and outlined on our Drug Formulary or Preferred Drug List without cost share. The formulary includes coverage for prescription and over the counter oral contraceptive products. In accordance with Illinois law, we allow for 12 month supply of oral contraceptives dispensed at one time. Some contraception methods are available through a *member's* medical benefit, including the insertion and removal of the contraceptive device at no cost share to the *member*. Emergency contraception is available to *members* without a prescription and at no cost share to the *member*.
10. Shingles coverage for a vaccine for shingles that is approved for marketing by the Federal Food and Drug Administration if the vaccine is ordered by a *physician* licensed to practice medicine in all its branches and the *member* is 60 years of age or older.
11. Coverage for Preventative Physical Therapy for Multiple Sclerosis Patients. As used here, "preventative physical therapy " means physical therapy that is prescribed by a physician licensed to practice medicine in all of its branches for the purpose of treating parts of the body affected by multiple sclerosis, but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.
12. Coverage for pulmonary rehabilitation therapy.
13. Coverage for cardiac outpatient rehabilitation services.
14. Coverage for osseointegrated auditory implants.
15. Routine hearing exams and hearing aids. Hearing aids limited to two items per 3 years.
16. Coverage for *medically necessary* massage therapy.

Prescription Drug Expense Benefits

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

1. A retail, mail order, generic, brand and specialty *prescription drug;*
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician;*
3. Self-injectable medications;
4. Insulin/needles for diabetes;
5. Fertility drugs;
6. Biological drugs;

7. Topical eye medication when the medication is to treat a chronic condition of the eye, the refill requested by the *member* prior to the last day of the prescribed dosage period and after at least 75% of the predicted days of use and the prescribing *physician* licensed to practice medicine in all its branches or optometrist indicates on the original prescription that refills are permitted and that the early refills requested by the *member* do not exceed the total number of refills;
8. Opioid antagonist; and
9. Growth hormone therapy.

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

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

Certain specialty and non-specialty generic medications may be covered at a higher *cost share* than other generic products. Please reference the formulary and *schedule of benefits* for additional information. For purposes of this section the tier status as indicated by the formulary will be applicable.

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

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

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

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

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

Drug Discount, Coupon or Copay Card:
Cost sharing paid on your behalf for any prescription drugs obtained by *you* through the use of a drug discount, coupon, or copay card provided by a prescription drug manufacturer will not apply toward *your* plan deductible or *your maximum out of pocket*.

Prescription Drug Synchronization
Under Illinois law you have the right to request synchronization of you medications. Synchronization is alignment of your fill dates so that all of your medication-refill dates are on the same day. For example if you fill medication A on the 5th of each month and your prescriber prescribes you a new prescription B on the 20th of the month, you have the right to request a refill for prescription B that is shorter or longer than 30 days. This may help you adjust your fill dates for medication B and synchronize the fill dates with medication A. We will adjust Copays to reflect shorter or longer coverage. If you would like to exercise this right please call our customer service line.

Step Therapy for Prescription Drugs
Our *contract* uses a requirement of Step Therapy for certain Prescription Drugs. We employ clinical pharmacists who review, research and analyze the efficacy and value of various drugs. Based on their reviews of clinical practice guidelines and recommended treatment of diseases, they recommend specific drugs as the first ones to try when a *member* begins or requires a change in medication therapy. For most people, these medications work well. In the limited instances where one of these medications isn't effective and/or appropriate for a particular *member*, the prescribing *physician* contacts us about approving coverage for a different medication. Trying medications in this "step-by-step" fashion is called Step Therapy. This also ensures that drugs are used in the appropriate clinical order for *your* medical condition.

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

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

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

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

Formulary exception process is applicable when:

1. The drug is not covered based on *our* formulary.
2. *We* are discontinuing coverage of the drug.
3. The prescription drug alternatives required to be used in accordance with a step therapy requirement:
    a. has been ineffective in the treatment; or
    b. has caused an adverse reaction or harm to a *member*. or
4. The number of doses available under a dose restriction for the prescription drug:
    a. has been ineffective in the treatment of the *member's* disease or medical condition; or
    b. the known relevant physical and mental characteristics of the member, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effective or patient compliance.

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

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

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance unless listed on the formulary.
2. For immunization agents, except when used for preventive care or required by the *Affordable Care Act*.
3. For medication that is to be taken by the *member,* at the place where it is dispensed.
4. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
5. For a refill dispensed more than 12 months from the date of a *physician's* order.
6. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
7. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary or when the over-the-counter drug is used for preventive care.
8. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
9. For more than a 31-day supply when dispensed in any one prescription or refill or for maintenance drugs up to 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply network order.
10. 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.
11. For any drug that we identify as therapeutic duplication through the drug *utilization review* program.
12. Foreign prescription medications, except those associated with an emergency medical condition while you are traveling 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.
13. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
14. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventative treatment is related to *member's* vacation for out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
15. Medications used for cosmetic purposes.

Special Rules for Prescription Drug Coverage:

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

Clinical Trial Coverage

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

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.

Phase I and II 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
2. The insured is enrolled in the clinical trial. This section shall not apply to insureds who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

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

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

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

Pediatric Vision Expense Benefits

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

1. Routine vision screening, including dilation and with refraction every calendar year.
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) in glass or plastic, or initial supply of contacts every calendar year:
    a. Other lens option included are: fashion and gradient tinting, ultraviolet protective coating, oversized and glass-grey #3 prescription sunglass lenses, polycarbonate lenses, blended segment lenses, intermediate vision lenses, standard progressives, premium progressives (Varilux®, etc), photochromic glass lenses, plastic photosensitive lenses (transitions®), polarized lenses, standard anti-reflective (AR) coating, premium AR coating, ultra AR coating and hi-index lenses
3. One pair of eyeglasses every calendar year; and
4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-*authorized*.

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

Medically Necessary Vision Services

Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by a participating provider (optometrist or ophthalmologist). *Covered services* include office visits, testing, and treatment of eye conditions producing symptoms that if left untreated may result in the loss of vision.

Excluded services for routine and non-routine vision include:
1. Visual therapy.
2. Any vision services, treatment or materials not specifically listed as a *covered service*.
3. Low vision services and hardware for adults.
4. Non-network care, except for pre-*authorized*.

Preventive Care Expense Benefits

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

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force which includes cervical cancer and HPV screening, colorectal cancer screening, ovarian cancer screening, prostate cancer screening and mammography screening.
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual.
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.

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

Covered Preventive Services for Adults including:

1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked;
2. Alcohol misuse screening and counseling;
3. Aspirin use for *members* of certain ages;
4. Blood pressure screening for all adults;
5. Cholesterol screening for adults of certain ages or at higher risk;
6. Colorectal Cancer screening for adults over 50;
7. Depression screening for adults;
8. Diabetes screening for adults with high blood pressure;
9. Diet counseling for adults at higher risk for chronic disease;
10. HIV screening and counseling for all adults at higher risk;
11. Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
    - Haemophilus influenza type b (HIB)
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza (Flu Shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella;
12. Obesity screening and counseling for all adults;
13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;
14. Tobacco use screening for all adults and cessation interventions for tobacco users; and
15. Syphilis screening for all adults at higher risk.
16. Falls prevention in older adults, exercise or physical therapy. The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls;
17. Falls prevention in older adults: vitamin D. The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls;
18. Hepatitis B screening: non-pregnant adolescents and adults. The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection;
19. Hepatitis C virus infection screening: adults. The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965. ;
20. Lung cancer screening. The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery;
21. Haemophilus influenza type b (HIB) 1 or 3 doses;
22. Skin cancer behavioral counseling. The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer;
23. Tuberculosis screening: adults. The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk;

Covered Preventive Services for Women and Pregnant Women include:

1. Anemia screening on a routine basis for pregnant *members*;
2. Bacteriuria urinary tract or other infection screening for pregnant *members*;
3. BRCA counseling and risk assessment about genetic testing for *members* at higher risk;

4. One cytologic screening per year or more often if recommended by a *physician*;
5. Screening mammography for all *members* over 35, baseline mammogram for *members* 35 to 39 years of age and annual mammogram for *members* 40 years of age and older, for *members* under 40 with a family history of breast cancer or other risk factors mammograms are covered at an age and interval considered *medically necessary*, a comprehensive ultrasound screening of an entire breast or breasts when a mammogram demonstrates *medical necessity* as described, a screening MRI when *medically necessary*, as determined by a *physician*, and a breast tomosynthesis;
6. Breast cancer chemoprevention counseling for *members* at higher risk;
7. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing *members*;
8. Cervical cancer screening for sexually active *members*;
9. Chlamydia infection screening for younger *members* and other *members* at higher risk;
10. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs;
11. Domestic and interpersonal violence screening and counseling for all *members*;
12. Folic Acid supplements for *members* who may become pregnant;
13. Gestational diabetes mellitus screening. The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation;
14. Gonorrhea screening for all *members* at higher risk;
15. Hepatitis B screening for pregnant *members* at their first prenatal visit;
16. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active *members*;
17. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for *members* with normal cytology results who are 30 or older;
18. Coverage for *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis;
19. Pre-eclampsia prevention;
20. Rh Incompatibility screening for all pregnant *members* and follow-up testing for *members* at higher risk;
21. Tobacco use screening and interventions for all *members*, and expanded counseling for pregnant; tobacco users;
22. Sexually Transmitted Infections (STI) counseling for sexually active *members*;
23. Syphilis screening for all pregnant *members* or other *members* at increased risk; and
24. Well-woman visits to obtain recommended preventive services.

Covered Preventive Services for Children including:

1. Alcohol and drug use assessments for adolescents;
2. Anticipatory Guidance: annually 3 years and older; more often if under 3 years;
3. Autism screening for children at 18 and 24 months;
4. Behavioral assessments for children through age 21;
5. Blood Pressure screening for children through age 21;
6. Cervical dysplasia screening for sexually active *members*;
7. Congenital hypothyroidism screening for newborns;
8. Depression screening for adolescents;
9. Developmental screening for children under age 3, and surveillance throughout childhood;
10. Dyslipidemia screening for children at higher risk of lipid disorders through age 21;
11. Fluoride chemoprevention supplements for children between 6 months and 5 years regardless of water source;
12. Gonorrhea preventive medication for the eyes of all newborns;
13. Hearing screening;
14. Height, weight and body mass index measurements for children through age 21;
15. Hematocrit or hemoglobin screening for children;
16. Hemoglobinopathies or sickle cell screening for newborns;

17. Hepatitis B screening: non-pregnant adolescents. The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection;
18. HIV screening for adolescents at higher risk;
19. Hypothyroid screening;
20. Immunization vaccines for children from birth to age 21 —doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis;
    - Haemophilus influenzae type b;
    - Hepatitis A;
    - Hepatitis B;
    - Human Papillomavirus;
    - Inactivated Poliovirus;
    - Influenza (Flu Shot);
    - Measles, Mumps, Rubella;
    - Meningococcal;
    - Pneumococcal;
    - Rotavirus;
    - Varicella.
21. Intimate partner violence screening: women of childbearing age. The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse;
22. Iron supplements for children ages 6 to 12 months at risk for anemia;
23. Lead screening;
24. Medical History for all children throughout development through age 21;
25. Newborn blood screening;
26. Obesity screening and counseling;
27. Oral health risk assessment for children;
28. Phenylketonuria (PKU) screening for this genetic disorder in newborns;
29. Physical Examination Procedures: critical congenital heart defect screening newborn;
30. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
31. Skin cancer behavioral counseling. The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer;
32. Tobacco use interventions: children and adolescents. The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents;
33. Tuberculin testing for children at higher risk of tuberculosis through age 21; and
34. Vision screening for all children.

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

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

If a *member* and/or dependents receive any other *covered services* during a preventive care visit, the *member* may be responsible to pay the applicable *copayment* and c*oinsurance* for those services.

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

You may access *our* website or the Member Services Department at 1-855-745-5507 (TTY/TDD 1-844-517-3431) to get the answers to many of *your* frequently asked questions regarding preventive services. *Our* website has resources and features that make it easy to get quality care. *Our* website can be accessed at Ambetter.IlliniCare.com.

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

Covered Services for Maternity Care:
An *inpatient* stay is covered for mother and newborn for a minimum of 48 hours following a vaginal delivery and 96 hours following a delivery by cesarean section. *We* do not require that a *physician* or other healthcare *provider* obtain *prior authorization*. An *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require *prior authorization*.

Other maternity benefits which may require *prior authorization* include:

a. *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, and childbirth classes.
b. *Physician* Home Visits and Office Services.
c. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
d. Complications of pregnancy.
e. *Hospital* stays for other *medically necessary* reasons associated with maternity care.

Note: This provision does not amend the *contract* to restrict any terms, limits, or conditions that may otherwise apply to *covered service* expenses for maternity care. This provision also does not require a *member* who is eligible for coverage under a health benefit plan to:

(1) give birth in a *hospital* or other healthcare facility; or
(2) remain under *inpatient* care in a *hospital* or other healthcare facility for any fixed term following the birth of a child.

Newborns' and Mothers' Health Protection Act Statement of Rights
Health Insurance Issuers generally may not, under federal law, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending *provider*, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a *provider* obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

1. Pre-transplant evaluation.
2. Pre-transplant harvesting.
3. Immunosuppressant drugs.
4. Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *member* to prepare for a later transplant, whether or not the transplant occurs.

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

Transplant Donor Expenses:
We will cover the medical expenses incurred by a live donor as if they were medical expenses of the *member* if:
1. They would otherwise be considered *covered service expenses* under the *contract;* and
2. The *member* received an organ or bone marrow of the live donor.

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

Benefits are available to both the recipient and donor of a covered transplant as follows: (1) If both the donor and recipient have coverage provided by the same insurer each will have their benefits paid by their own program. (2) If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this *contract* will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits. (3) If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this *contract* will be provided for you. However, no benefits will be provided for the recipient. Benefits will be provided for: (1) *Inpatient* and outpatient covered services related to the transplant surgery. (2) The evaluation, preparation and delivery of the donor organ. (3) The removal of the organ from the donor. (4) The transportation of the donor organ to the location of the transplant surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada. Benefits will only be provided at in-network approved Human Organ Transplant Coverage Program.

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these transplant expense benefits:
1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.
2. For animal to human transplants.
3. To keep a donor alive for the transplant operation.
4. Left Ventricular Assist Devices (LVAD) when used as destination.
5. Total artificial heart is not covered (even though it is a bridge to transplant).
6. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
7. Related to transplants not included under this provision as a transplant.
8. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("USFDA") regulation, regardless of whether the trial is subject to USFDA oversight.

Organ Transplant Medication Notification
At least 60 days prior to making any formulary change that alters the terms of coverage for a patient receiving *immunosuppressant drugs* or discontinues coverage for a prescribed *immunosuppressant drug* that a patient is receiving, we must, to the extent possible, notify the prescribing *physician* and the patient, or the parent or guardian if the patient is a child, or the *spouse* of a patient who is *authorized* to consent to the treatment of the

patient. The notification will be in writing and will disclose the formulary change, indicate that the prescribing *physician* may initiate an appeal, and include information regarding the procedure for the prescribing *physician* to initiate the *contract*'s appeal process.

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

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

PRIOR AUTHORIZATION

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

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

1. Receive a service or supply from a *non-network provider;*
2. Are admitted into a *network* facility by a *non-network provider;* or
3. Receive a service or supply from a *network provider* to which *you* or *your dependent member* were referred by a non-*network provider.*

Prior Authorization requests must be received by telephone, fax 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 any inpatient admission, including emergent inpatient admissions.
5. At least 5 days prior to the start of home health care except those *members* needing home health care after hospital discharge.

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

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

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

Failure To Obtain Prior Authorization
Failure to comply with the *prior authorization* requirements will result in benefits being reduced. There is a penalty if treatment is not *authorized* prior to service. The penalty is a 20% reduction of the eligible expenses for all charges related to the treatment, not to exceed $1,000. The penalty applies to all otherwise eligible expenses that are:

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

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

In cases of emergency, benefits will not be reduced for failure to comply with *prior authorization* requirements. 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. Another party has already paid or is responsible for payment of the medical expense.

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

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

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

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

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

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

Services from Non- Network Providers
Except for *emergency* medical services and nonparticipating facility-based *physician* and provider, unless *covered services* are not available from *network providers* within a reasonable proximity such services will not be covered. If required *medically necessary* services are not available from *network providers* you or the *network provider* must request *prior authorization* from us before you may receive services from *non-network providers*. Otherwise you will be responsible for all charges incurred.

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

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

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract,* except as expressly provided for under the Benefits After Coverage Terminates clause in this *contract's* Termination section.
2. For any portion of the charges that are in excess of the *eligible service expense.*
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery,* except if required by state law.
4. For cosmetic breast reduction or augmentation, except for the *medically necessary* treatment of Gender Dysphoria.
5. For the reversal of sterilization and reversal of vasectomies.
6. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
7. For expenses for television, telephone, or expenses for other persons.
8. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
9. For telephone consultations, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
10. For stand-by availability of a *medical practitioner* when no treatment is rendered.
11. For *dental service expenses,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Medical Service Benefits.
12. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect.
13. For Mental health exams and services involving:
    a. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities,
    b. Marriage counseling,
    c. Pre-marital counseling,
    d. Court-ordered care or testing, or required as a condition of parole or probation,
    e. Testing of aptitude, ability, intelligence or interest, or
    f. Evaluation for the purpose of maintaining employment inpatient confinement or inpatient mental health services received in a residential treatment facility.
14. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
15. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.

16. 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.
17. 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*. Coverage for eyeglasses is listed under Outpatient Medical Supplies Expense Benefits and Pediatric Vision Expense Benefits.
18. 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.
19. For treatment received outside the United States, except for a medical *emergency*.
20. 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.
21. For or related to surrogate parenting.
22. For or related to treatment of hyperhidrosis (excessive sweating).
23. For fetal reduction surgery.
24. Except as specifically identified as a *covered service expense* under the *contract*, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
25. 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.
26. For the following miscellaneous items: artificial insemination (except where required by federal or state law); chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service area; transportation expenses, unless specifically described in this *contract*.
27. For court ordered testing or care unless *medically necessary*.
28. 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.
29. Services or care provided or billed by a school, custodial care center for the developmentally disabled.
30. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
31. Biofeedback.

Exceptions to Limitations:

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

TERMINATION

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

1. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *contract* (including, but not limited to, the Grace Period provision) or the date that we have not received timely premium payments in accordance with the terms of this *contract*; or
2. The date of termination that the Health Insurance Marketplace provides us upon your request of cancelation; or
3. For a Dependent Child Reaching the Limiting Age of 26, Coverage under this contract, for a Dependent Child, will terminate at 11:59 p.m. on the last day of the year in which the Dependent Child reaches the limiting age of 26; or
4. The date we decline to renew this *contract*, as stated in the discontinuance provision of this *contract*; or
5. The date of your death; or
6. The date a *member's* eligibility for coverage under this Contract ceases as determined by the Health Insurance Marketplace; or
7. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or
8. The date the primary *member* no longer resides or lives in the *service area* of this plan.

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

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

180-Day Notice: If *we* discontinue offering and refuse to renew all individual *contracts* in the individual market in the state where *you* reside, *we* will provide a written notice to *you* and the Commissioner of Insurance at least 180 days prior to the date that *we* stop offering and terminate all existing individual *contracts* in the individual market in the state where *you* reside.

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

Continuity of Care
We shall develop procedures to provide for the continuity of care of *members*. *W*e shall ensure that:

1. When a *member* is enrolled in an Ambetter plan and is being treated by a *non-network provider* for a current episode of an acute condition, the *member* may continue to receive treatment as an in-*network*

benefit from that provider until the current episode of treatment ends or until the end of ninety (90) days, whichever occurs first; and

2. When a provider*'s* participation is terminated, the provider's patients under the plan may continue to receive care from that provider as an in-network benefit until a current episode of treatment for an acute condition is completed or until the end of ninety (90) days, whichever occurs first.

During the periods covered by (1) and (2) of this section, the provider shall be deemed to be a *network provider* for purposes of reimbursement, utilization management, and quality of care.

Reinstatement

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

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

CLAIMS

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

Proof Of Loss
We must receive written *proof of loss* within 180 days of the *loss* for *in-network providers* and within 90 days of the *loss* for *non-network providers*. *Proof of loss* furnished after these timeframes will not be accepted, unless *you* or *your* covered *dependent member* had no legal capacity to submit such proof during that year.

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

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

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

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

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

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

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

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

Upon request by the custodial parent, *we* will:

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

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

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

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

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

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

Grievance Process
A grievance or complaint is an expression of dissatisfaction regarding our products or services. You or your designee may submit a grievance verbally or in writing. . You have up to **60 calendar days** to file a grievance. The 60 calendar days start on the date of the situation you are not satisfied with. Depending on the nature of the grievance and whether or not a response is requested, we will respond verbally and/or in writing within sixty (60) business days following receipt of the grievance, or should a *member's* medical condition necessitate an expedited review a response within 24 hours. We may extend the response time for up to an additional 30 days in the event additional information is required.

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

Coordination of Benefits with a Medicare plan
If a *member* and/or *dependent* is enrolled in Medicare and Ambetter from IlliniCare Health, Medicare will be the primary payer and Ambetter from IlliniCare Health will be the secondary payer. Ambetter from IlliniCare Health will not pay benefits until after Medicare has paid its share of the costs. Ambetter from IlliniCare Health

will reimburse part or all of the allowable expense left unpaid. The *member* will be responsible for the remaining out-of-pocket expenses as applicable.

A *member* or *dependent* enrolled in Ambetter from IlliniCare Health and Medicare is required to notify the Federally Facilitated Marketplace (FFM) to dis-enroll from the Health Insurance Marketplace plan and Ambetter from IlliniCare Health. The *member*'s profile will be updated to indicate the *member* has Medicare coverage. *Members* will no longer be eligible to receive a premium subsidy for the Health Insurance Marketplace plan once Medicare part A coverage becomes effective.

Non-Assignment

The coverage, rights, privileges and benefits provided for under this *contract* are not assignable by *you* or anyone acting on *your* behalf. Any assignment or purported assignment of coverage, rights, privileges and benefits provided for under this *contract* that *you* may provide or execute in favor of any *hospital*, *provider*, or any other person or entity shall be null and void and shall not impose any obligation on *us*.

No Third Party Beneficiaries

This *contract* is not intended to, nor does it, create or grant any rights in favor of any third party, including but not limited to any *hospital, provider* or *medical practitioner* providing services to *you*, and this *contract* shall not be construed to create any third party beneficiary rights.

INTERNAL CLAIMS AND APPEALS PROCEDURES AND EXTERNAL REVIEW

INTERNAL PROCEDURES

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

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

In the event the *grievance* means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing in any form to the insurer by, or on behalf of, a *member* including any of the following:
1. Provision of services;
2. Determination to reform or rescind a contract;
3. Determination of a diagnosis or level of service required for evidence-based treatment of *autism spectrum disorders*; and
4. Claims practices.
5. is unable to give consent: a *spouse*, family member, or the treating provider; or
6. In the event of an *expedited grievance*: the person for whom the insured has verbally given authorization to represent the *member*.

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

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

Ambetter from IlliniCare Health
Attn.: Appeals and Grievances
P.O. Box 92050
Elk Grove Village, IL 60009-2050
Phone # 1-855-745-5507
TTY/TDD 1-844-517-3431
Fax # 1-877-668-2076
Email: gareferrals@centene.com

A *member* has the right to request an internal review in tandem with a provider's request for an expedited internal review or a concurrent review is in process.

Grievances will be promptly investigated and presented to the internal *grievance* panel. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of an appeal.

Resolution Timeframes

1. *Grievances* regarding quality of care, quality of service, or *reformation* will be resolved within 60 calendar days of receipt. The time period may be extended for an additional 30 calendar days, making the maximum time for the entire *grievance* process 90 calendar days if *we* provide the *member* and the *member's* authorized representative, if applicable, written notification of the following within the first 30 calendar days:
    a. That *we* have not resolved the *grievance*;
    b. When *our* resolution of the *grievance* may be expected; and
    c. The reason why the additional time is needed.
2. All other *grievances* will be resolved and *we* will notify the *member* in writing with the appeal decision within the following timeframes:
    a. *Post-service claim*: within 15 business days after receipt of the member's request for internal appeal;
    b. *Pre-service claim*: within 15 business days after receipt of the *member's* request for internal appeal.

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

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

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

Acknowledgement

Within three business days of receipt of a *grievance*, a written acknowledgment to the *member* or the *member*'s authorized representative confirming receipt of the *grievance* must be delivered or deposited in the mail.

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

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

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

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

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

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

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

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

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

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

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

Complaints filed directly with the Illinois Department of Insurance should be sent to the following:

Office of Consumer Health Insurance
320 W. Washington Street
Springfield, IL 62767
Toll-free Phone No. 1-877-527-9431
Facsimile No. 1-217-558-2083
complaints@ins.state.il.us
https://mc.insurance.illinois.gov/messagecenter.nsf

Complaints received from the State Insurance Department
The commissioner may require *us* to treat and process any *complaint* received by the State Insurance Department by, or on behalf of, a *member* as a *grievance* as appropriate. *We* will process the State Insurance Department *complaint* as a *grievance* when the commissioner provides *us* with a written description of the *complaint*.

External Review
An external review decision is binding on *us*. An external review decision is binding on the *member* except to the extent the claimant has other remedies available under applicable federal or state law. *We* will pay for the costs of the external review performed by the independent reviewer.

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

Applicability/Eligibility
The g*rievance* procedures apply to:
1. Any hospital or medical policy, *contract* or certificate; excluding accident only or disability income only insurance; or

2. Conversion plans.

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

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

External review is available for *grievances* that involve:

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

External Review Process

Request For External Review

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

Exhaustion of Internal Appeal Process

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

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

1. the *member* or the *member's* authorized representative has filed an appeal under *our* internal appeal process and has not received a written decision on the appeal 15 business days following the date the *member* or the *member 's* authorized representative files an appeal of an adverse determination that involves a concurrent or prospective review request or 15 business days following the date the *member* or the *member's* authorized representative files an appeal of an adverse determination that involves a retrospective review request, except to the extent the *member* or the *member's* authorized representative requested or agreed to a delay;

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

Standard External Review

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

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

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

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

If the request:

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

2. is not eligible for external review, *we* shall inform the Director and *member* and, if applicable, the *member's* authorized representative in writing and include in the notice the reasons for its ineligibility.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The independent review organization shall include in the notice:

1. a general description of the reason for the request for external review;
2. the date the independent review organization received the assignment from the Director to conduct the external review;
3. the time period during which the external review was conducted;
4. references to the evidence or documentation, including the evidence-based standards, considered in reaching its decision;
5. the date of its decision;
6. the principal reason or reasons for its decision, including what applicable, if any, evidence-based standards that were a basis for its decision; and
7. the rationale for its decision.

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

Expedited External Review

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

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

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

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

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

1. Assignment of an approved independent review organization to conduct an external review in accordance with this Section shall be made from those approved independent review organizations qualified to conduct external review as required by Sections 50 and 55 of this Act.
2. The Director shall immediately notify *us* of the name of the assigned independent review organization. Immediately upon receipt from the Director of the name of the independent review organization assigned to conduct the external review, but in no case more than 24 hours after receiving such notice, *we* or *our* designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.
3. If *we* or *our* utilization review organization fails to provide the documents and information within the specified timeframe, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.
4. Within one business day after making the decision to terminate the external review and make a decision to reverse the adverse determination or final adverse determination, the independent review organization shall notify the Director, *us*, the *member*, and, if applicable, the *member's* authorized representative of its decision to reverse the adverse determination or final adverse determination.

In addition to the documents and information provided by us or *our* utilization review organization and any documents and information provided by the *member* and the *member's* authorized representative, the

independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider information in reaching a decision.

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

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

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

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

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

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

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

External Review of Experimental or Investigational Treatment Adverse Determinations

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

The following provisions apply to cases concerning expedited external reviews:

1. A *member* or the *member's* authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination if the covered person's treating *physician* certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.
2. Upon receipt of a request for an expedited external review, the Director shall immediately notify the health carrier.
3. The following provisions apply concerning notice:
    a. Upon notice of the request for an expedited external review, the health carrier shall immediately determine whether the request meets the reviewability requirements. *We* shall immediately notify the Director and the *member* and, if applicable, the *member's* authorized representative of its eligibility determination.
    b. The Director may specify *our* notice of initial determination and any supporting information to be included in the notice. The notice of initial determination under shall include a statement informing the *member* and, if applicable, the *member's* authorized representative of *our* initial determination that the external review request is ineligible for review may be objected to the Director by filing a *complaint* with the Illinois Department of Insurance.
4. The following provisions apply concerning the Director's determination:

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

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

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

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

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

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

The following provisions apply concerning requests:

1. Within one business day after completion of the preliminary review, *we* shall notify the Director and *member* and, if applicable, the *member's* authorized representative in writing whether the request is complete and eligible for external review.

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

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

Whenever the Director receives notice that a request is eligible for external review following the preliminary review conducted, within one business day after the date of receipt of the notice, the Director shall:
1. assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Director and notify *us* of the name of the assigned independent review organization; and
2. notify in writing the *member* and, if applicable, the *member's* authorized representative of the request's eligibility and acceptance for external review and the name of the independent review organization.

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

The following provisions apply concerning assignments and clinical reviews:
1. Within one business day after the receipt of the notice of assignment to conduct the external review, the assigned independent review organization shall select one or more clinical reviewers, as it determines is appropriate, to conduct the external review.
2. The provisions of this item apply concerning the selection of reviewers:
    a. In selecting clinical reviewers, the assigned independent review organization shall select *physicians* or other health care professionals who meet the minimum qualifications and, through clinical experience in the past 3 years, are experts in the treatment of the *member's* condition and knowledgeable about the recommended or requested health care service or treatment.
    b. Neither *we*, the *member* or *member's* authorized representative will choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

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

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

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

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

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

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

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

The following provisions apply concerning clinical review opinions:

4. within 45 days after being selected, each clinical reviewer shall provide an opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.
5. Except for an opinion, each clinical reviewer's opinion shall be in writing and include the following information:
    a. a description of the *member's* medical condition;
    b. a description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the *member* than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;
    c. a description and analysis of any medical or scientific evidence considered in reaching the opinion;
    d. a description and analysis of any evidence-based standard; and
    e. information on whether the reviewer's rationale for the opinion is based on.

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

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

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

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

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

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

1. The provisions of this item apply concerning decisions and notices:
    a. Except as provided, within 20 days after the date it receives the opinion of each clinical reviewer, the assigned independent review organization, shall make a decision and provide written notice of the decision to the Director, *us*, the *member*, and the *member's* authorized representative, if applicable.
    b. For an expedited external review, within 72 hours after the date it receives the opinion of each clinical reviewer, the assigned independent review organization, shall make a decision and provide notice of the decision orally or in writing to the Director, *us*, the *member*, and the *member's* authorized representative, if applicable. If such notice is not in writing, within 72 hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the Director, *us*, the *member*, and the *member's* authorized representative, if applicable. The independent review organization has 5 days to provide notice of the decision for expedited *experimental* reviews.

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

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

carrier's adverse determination or final adverse determination.

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

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

The independent review organization shall include in the notice provided:

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

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

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

Binding Nature of External Review Decision

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

If a *member* has a change in medical status for a treatment or procedure not previously approved, the *member* may become eligible for a subsequent external review.

Disclosure Requirements

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

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

GENERAL PROVISIONS

Entire Contract
This *contract,* with the application*,* is the entire contract between *you* and *us.* No agent may:

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

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

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

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

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

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

Statement of Non-Discrimination

Ambetter from IlliniCare 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 IlliniCare Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from IlliniCare 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 IlliniCare Health at 1-855-745-5507 (TTY/TDD 1-844-517-3431).

If you believe that Ambetter from IlliniCare 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: Ambetter from IlliniCare Health, Attn: Appeals and Grievances, PO Box 92050, Elk Grove Village, IL 60009-2050, 1-855-745-5507 (TTY/TDD 1-844-517-3431), Fax 1-877-668-2076, Email gareferrals@centene.com. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from IlliniCare 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*.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from IlliniCare Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Polish:	Jeżeli ty lub osoba, której pomagasz, macie pytania na temat Ambetter from IlliniCare Health, macie prawo poprosić o bezpłatną pomoc i informacje w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from IlliniCare 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 1-855-745-5507 (TTY/TDD 1-844-517-3431)。
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from IlliniCare Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-855-745-5507 (TTY/TDD 1-844-517-3431) 로 전화하십시오.
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from IlliniCare Health, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from IlliniCare Health ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from IlliniCare Health вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Gujarati:	જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter from IlliniCare Health વિશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-855-745-5507 (TTY/TDD 1-844-517-3431) ઉપર કૉલ કરો.
Urdu:	اگر Ambetter from IlliniCare Health کے بارے میں آپ، یا جن کی آپ مدد کررہے ہیں ان کے سوالات ہوں تو، آپ کو بلامعاوضہ اپنی زبان میں مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی مترجم سے بات کرنے کے لیے، 1-855-745-5507 (TTY/TDD 1-844-517-3431)، پر کال کریں۔
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from IlliniCare 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 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Italian:	Se lei, o una persona che lei sta aiutando, avesse domande su Ambetter from IlliniCare Health, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l'1-855-745-5507 (TTY/TDD 1-844-517-3431).
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from IlliniCare 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 1-855-745-5507 (TTY/TDD 1-844-517-3431) पर कॉल करें।
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d' Ambetter from IlliniCare Health, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Greek:	Εάν εσείς ή κάποιος που βοηθάτε, έχετε ερωτήσεις σχετικά με την Ambetter from IlliniCare Health, έχετε το δικαίωμα να ζητήσετε βοήθεια και πληροφορίες στη γλώσσα σας, χωρίς χρέωση. Για να μιλήσετε με διερμηνέα, καλέστε το 1-855-745-5507 (TTY/TDD 1-844-517-3431).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from IlliniCare 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 1-855-745-5507 (TTY/TDD 1-844-517-3431) an.