ambetter. FROM mhs

2019 Evidence of Coverage

Ambetter.mhsindiana.com

76179IN013

Celtic Insurance Company
Ambetter from MHS

Home Office: 200 East Randolph, Chicago, IL 60601
Individual Member 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 Celtic Insurance Company or Ambetter from MHS.

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 c*ontract* (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 c*ontract* 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; (2) *we* withdraw from the *Service Area* or reach demonstrated capacity in a *Service Area* in whole or in part; or (3) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *Member* in filing a claim for Covered Services.

In addition to the above, this guarantee for continuity of coverage shall not prevent *us* from cancelling or non-renewing this c*ontract* in the following events: (1) non-payment of premium; (2) a *Member* moves outside the *Service Area*; (3) a *Member* fails to pay any *Deductible* or *Copayment* Amount owed to *us* and not the Provider of services; (4) a *Member* is found to be in material breach of this *contract*; or (5) a change in federal or state law no longer permits the continued offering of such coverage, such as CMS guidance related to individuals who are Medicare eligible.

Annually, *we* may 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 *member*s, type and level of benefits, and place of residence on the premium due date are some of the factors used in determining *your* premium rates. *We* have the right to change premiums.

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

Celtic Insurance Company

Anand Shukla
Senior Vice President
Individual Health

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INTRODUCTION

Welcome to Ambetter from MHS! *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* health care costs *you* will be required to pay.

This *contract*, the *Schedule of Benefits*, the application as submitted to the Health Insurance Marketplace, 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 see references to Celtic Insurance Company and Ambetter from MHS. Ambetter from MHS operates under its legal entity, Celtic Insurance Company, and both may be referred to as the "plan."

How to Contact Us
Ambetter from MHS
550 North Meridian Street
Suite 101
Indianapolis, IN 46204

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST
Member Services **1-877-687-1182**
TDD/TTY line **1-800-743-3333**
Fax **1-877-941-8072**
Emergency **911**
24/7 Nurse Advice Line **1-877-687-1182**

Interpreter Services
Ambetter from MHS 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 medical interpreters to assist with languages other than English via phone. An interpreter will not go to a Provider's office with *you*. *Member*s

who are blind or visually impaired and need help with interpretation can call Member Services for oral interpretation, or to request materials in Braille or large font.

To arrange for interpretation services, please call Member Services at 1-877-687-1182 (TDD/TTY 1-800-743-3333).

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*.
6. Providing coverage regardless of age, ethnicity, race, religion, gender, sexual orientation, national origin, physical or mental disability, or expected health or genetic status.

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 *grievances* 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:
    a. Any changes in clinical review criteria; or
    b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
13. A current list of *network providers*.
14. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
15. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, 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 provider 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. *Member*s 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* I.D. card and keep scheduled appointments with *your physician*, and call the *physician*'s

office during office hours whenever possible if *you* have a delay or cancellation.

6. Know the name of *your* assigned *primary care provider*. *You* should establish a relationship with *your provider*. *You* may change *your primary care provider* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* 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* 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 (either the Marketplace or *us)*.
15. Pay *your* monthly premiums on time and pay all *deductible amounts, copayment amounts*, or *cost-sharing percentages* at the time of service.
16. Inform the entity in which *you* enrolled for this *contract* if *you* have any changes in *your* name, address, or family members covered under this *contract* within 60 days from the date of the event.
17. Verify the participating *network* status of *your* medical providers including providers that *you* are referred to by *your primary care provider* or other Ambetter from MHS *network provider.*

Your Provider Directory

A listing of *network providers* is available online at Ambetter.mhsindiana.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 Ambetter from MHS 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.

In addition to online availability, *you* can request a copy of the provider directory at no charge by calling Member Services at 1-877-687-1182 (TDD/TYY 1-800-743-3333). 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 1-877-687-1182 (TDD/TYY 1-800-743-3333). *We* will help *you* make the appointment.

Your Member ID Card

When *you* enroll, *we* will mail a Member ID card to *you* after *we* receive *your* completed enrollment materials which includes receipt of *your* initial binder payment. This card is proof that *you* are enrolled in the Ambetter plan. *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 1-877-687-1182. *We* will send *you* another card.

Our Website

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

1. Finding a *network provider*.
2. *Our* programs and services, including programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the status of *your* claims, make payments and obtain a copy of *your* Member ID card.
4. Member Rights and Responsibilities.
5. Notice of Privacy.
6. Current events and news.
7. *Our* Formulary or Preferred Drug List.
8. *Deductible* and *copayment* accumulators.
9. Selecting a *Primary Care Provider*.
10. Health Risk Assessment form, "Welcome Survey."

Quality Improvement

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

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

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

We believe that getting *member* input can help make the content and quality of *our* programs better. *We*

conduct a *member* survey each year that asks questions about *your* experience with the healthcare and services *you* are receiving.

Health Management Programs Offered

Ambetter from MHS 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.mhsindiana.com or by contacting Member Services at 1-877-687-1182 (TDD/TYY 1-800-743-3333).

DEFINITIONS

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

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

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

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

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

Refer to the Internal Grievance, Internal Appeals and External Appeals Procedures section of this *contract* for information on *your* right to appeal an *adverse benefit determination.*

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

Applied behavior analysis Applied behavioral 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.

Autism spectrum disorder means 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.

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 primary care provider* 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 appeals 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.

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*; this is *your* responsibility. *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.

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 *medically necessary* 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*.

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

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

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy and not, from a medical viewpoint, associated with a normal pregnancy. This includes: ectopic pregnancy, spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, *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 percentage means the percentage of *covered services* that are payable by *us*.

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

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

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

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

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

1. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
2. Preparation and administration of special diets;
3. Supervision of the administration of medication by a caregiver;
4. Supervision of self-administration of medication; or

5. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, sanatoria care, educational care or recreational care.

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

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

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

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

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

Dependent member means *your* lawful *spouse* 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 child means the child of a covered person, if that child is less than 26 years of age. As used in this definition, "child" means:

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

It is *your* responsibility to notify the entity with which *you* enrolled (either the Health Insurance 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*.

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

1. For *network providers*: When a *covered service is* received from a *network provider*, the *eligible service expense* is the contracted fee with that provider.

2. For non-*network providers*:

   a. When a *covered service* is received from a *non-network provider* as a result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the provider as payment in full (*you* will not be billed for the

difference between the negotiated fee and the provider's charge). However, if the provider has not agreed to accept a negotiated fee with *us* as payment in full, the *eligible service expense* is the greatest of the following:

i. the amount that would be paid under Medicare,

ii. the amount for the *covered service* calculated using the same method *we* generally use to determine payments for out-of-network services, or

iii. the contracted amount paid to *network providers* for the *covered service*. If there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts.

You may be billed for the difference between the amount paid and the provider's charge.

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 greater of (1) the amount that would be paid under Medicare, or (2) the contracted amount paid to *network providers* for the *covered service*. If there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts. *You* may be billed for the difference between the amount paid and the provider's charge.

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

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) which requires immediate (no later than 24 hours after onset) medical or surgical care**.** If *you* are experiencing an *emergency*, call 9-1-1 or go to the nearest *hospital*. Services which *we* determine meets the definition of *emergency* will be covered by any provider. Such conditions that manifest with acute symptoms are those that an average person who possesses 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 pregnancy, 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.

Follow-up care is not considered Emergency Care. Benefits are provided for treatment of *emergency* medical conditions and *emergency* screening and stabilization services without *prior authorization*. Benefits for *emergency* care include facility costs and *physician* services, and supplies and *prescription drugs* charged by that facility. *You* must notify *us* or verify that *your* physician has notified *us* of *your* admission to a *hospital* within one business day or as soon as possible within a reasonable period of time.

When *we* are contacted, *you* will be notified whether the *inpatient* setting is appropriate, and if appropriate, the number of days considered *medically necessary*. By contacting *us*, *you* may avoid financial responsibility for any *inpatient* care that is determined to be not *medically necessary* under *your* plan. If *your* provider does not contract with *us you* will be financially responsible for any care *we* determine is not *medically necessary*. Care and treatment provided once *you* are medically stabilized is no longer considered *emergency* care. Continuation of care from a *non-network provider* beyond that needed to evaluate or stabilize *your* condition in an *emergency* will be covered as a non-network service unless *we authorize* the continuation of care and it is *medically necessary*. *You* may be balance billed for any *covered services* provided by a *non-network provider*.

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 claimant to regain maximum function.
2. In the opinion of a *physician* with knowledge of the claimant'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*.
3. A *physician* with knowledge of the claimant'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 (*"FDA"*) regulation, regardless of whether the trial is subject to *USFDA* oversight.
2. An *unproven service.*
3. Subject to *FDA* approval, and:
    a. It does not have *FDA* approval;
    b. It has *FDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has *FDA* 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 *FDA*-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 *FDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *FDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*
4. Experimental or investigational according to the provider's research protocols.

Items (3) and (4) above do not apply to phase III or IV *FDA* clinical trials. Benefits are available for routine care costs that are incurred in the course of a clinical trial if the services provided are otherwise covered services under this *contract.*

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 *generally accepted standards of medical practice* for that condition.

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

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

If no credible scientific evidence is available, then standards 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 claimant including any of the following:

1. A determination that a service or benefit is not deemed appropriate or *medically necessary;*
2. Determination to rescind the *contract;*
3. Determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders;
4. The handling or payment of claims for services or benefits as covered in this *contract*;
5. A determination that a service or benefit is deemed to by experimental or investigational in nature;
6. The availability of providers;
7. Matters pertaining to the contractual relationship between the covered individual and the health plan, or

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 *generally accepted standards of medical practice* for the *injury* or *illness* requiring the *home health care.*

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

Hospice means an institution that:

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

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

Hospital means an institution that:

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

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

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

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

Injury means accidental bodily damage sustained by a *member* 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 services, supplies, or treatment for medical, behavioral health or *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.

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

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

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

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, *we* pay 100% of *eligible service expenses* for that individual. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket* amount. Both the individual and the family *maximum out-of-pocket amounts* are shown in the *Schedule of Benefits*.

For family coverage, the family *maximum out-of-pocket* amount can be met with the combination of any covered 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 out-of pocket maximum 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 includes but is not limited to a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *contract:* acupuncturist, speech therapist, occupational therapist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, *emergency* medical technician, social worker, family counselor, marriage counselor, child counselor, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. Is provided in the most cost effective care facility or setting;
7. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; and

8. When specifically applied to a *hospital* confinement, it means that the diagnosis and treatment of *your* medical symptoms or conditions cannot be safely provided as an outpatient.

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

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

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

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

Mental disorder means a behavioral, emotional, or cognitive condition that is listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD).

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

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

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

Network eligible service expense means the *eligible 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 sometimes referred to as an "in-network provider," means a *medical practitioner* who contracts with *us* or *our* contractor or subcontractor and has agreed to provide healthcare services to *our members* with an expectation of receiving payment, other than *copayment* or *deductible*, directly or indirectly, from us. These providers will be identified in the most current Provider Directory for the network.

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

Non-network provider means a *medical practitioner* who is NOT identified in the most current Provider Directory 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*.

Ombudsman Program means a program that provides Ambetter from MHS *member*s free and easy access to an independent party which will investigate the *member's* concern(s), provide *member* education, and help *members* contact the right people for assistance within the Health Insurance Marketplace and Ambetter programs.

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.*

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

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

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

Preceding prescription drug as a condition of coverage for succeeding treatment with another *prescription drug,* means a *prescription drug* that, according to a step therapy protocol, must be first used to treat an insured's condition and determined to be inappropriate.

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 service expenses*.

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

Primary care provider (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 primary care provider* or provider group prior 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 claims 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.

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

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

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

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

Rehabilitation means care for restoration (including by education or training) of one's prior ability to function at a level of *maximum therapeutic benefit*. This includes *acute rehabilitation*, *sub-acute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy* and cardiac rehabilitation. 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.

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

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

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

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

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

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

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

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

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

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

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 Indiana 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 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.

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 (DSM) and the International Classification of Diseases (ICD).

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 health care services delivered by use of interactive audio, video, or other electronic media, including the following:
1. Medical exams and consultations.
2. Behavioral health, including *substance use* evaluations and treatment.

The term does not include the delivery of health care services by use of the following:
1. A telephone transmitter for transtelephonic monitoring.
2. A telephone or any other means of communication for the consultation from one (1) provider to another provider.

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

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

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

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

Unproven service(s) means services, including medications, which 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 insurance on the latter of:

1. The date *you* became covered under this *contract;* or
2. The date of marriage to add a spouse; or
3. The date of a newborns birth; or
4. The date that an adopted child is placed with *you* or *your* spouse for the purposes of adoption or *you* or *your* spouse 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 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 covered 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. The required premium will be calculated from the child's date of birth. If notice of the newborn is given to *us* by the Health Insurance Marketplace within the 31 days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 days after the birth of the child. If notice is not given with 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 by the entity through which *you* enrolled (either the Health Insurance Marketplace or us) of the child's birth.

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

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

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

As used in this provision, *"placement"* means the earlier of:

1. The date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption; or
2. The date of entry of an order granting *you* or *your spouse* custody of the child for the purpose of adoption.

Adding Other Dependent Members
If *you* are enrolled in an off-Marketplace 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 member.*

ONGOING ELIGIBILITY

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

1. The date the primary *member* resides outside the *service area* or moves permanently outside the *service area* of this plan;
2. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact ;
3. The date of a *member's* death;
4. 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
5. 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 handicap or physical handicap that began before the age limit was reached; and
2. Mainly dependent on *you* for support.

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.

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 *advance premium tax credits* 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 *advance 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 the first of September, and no later than the thirtieth of September.

Special and Limited 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 of a *member* or their spouse; 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, misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace or HHS, or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction; 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 premium tax credits* 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.

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.

If *you* have material modifications (examples include a change in life event such as marriage, death or other change in family status), or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596. If *you* enrolled through Ambetter contact Member Services at 1-877-687-1182.

PREMIUMS

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

Grace Period
When a *member* is receiving a premium subsidy:
After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if *advance premium tax credits* are received.

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

When a *member* is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a one (1) month grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *contract* will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. *We* will notify HHS, as necessary, of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the grace period.

Premium Payments from Third-Party Payors
The *member* is responsible for payment of premiums to Ambetter from MHS. *We* do not accept direct or indirect payment of Premiums from any person or entity other than the Policyholder, his or her dependents, or an Acceptable Third-Party payor. "Acceptable Third Party Payors" are payors which have no incentive for financial gain, no financial relationship or affiliation with providers of covered services or supplies. *We* will accept payments from the following payors which make payments on behalf of *member*'s needs including the following:

- Ryan White HIV/AIDS Program under Title XXVI of the Public Health Services Act,
- Indian tribes, tribal organizations or urban Indian organizations,
- Local, State and Federal government programs or grantees under such programs,
- Private, not-for-profit foundations, including end stage renal disease providers,
- Family *member*s.
- 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.

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

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*.

COST SHARING FEATURES

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

Copayments
Members may be required to pay *copayments* at the time of services as shown in the *Schedule of Benefits*. Payment of a *copayment* does not exclude the possibility of an additional billing if the service is determined to be a non-*covered service*. *Copayments* do not apply toward the *deductible amount*, but do apply toward meeting the *maximum out-of-pocket amount.*

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

Deductible
The *deductible amount* means the amount of *covered service expenses* that must be paid by 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*; and

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

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

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

Individual *members* must satisfy federal HSA eligibility criteria in order to open and contribute to an HSA.

This Evidence of Coverage is administered by Ambetter from MHS and underwritten by Celtic Insurance Company. Neither entity is an HSA trustee, HSA custodian or a designated administrator for HSAs. Celtic Insurance Company, its designee and its affiliates, including Ambetter from MHS, do not contribute to the HSA or provide tax, investment or legal advice to *members*.

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

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

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

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. However, *you* may not change *your* selection more frequently than once each month. If *you* do not select a *network primary care provider* for each *member,* one will be assigned. *You* may obtain a list of *network primary care providers* at *our* website or by contacting *our* Member Services department.

Your network primary care provider will be responsible for coordinating all covered health services 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.

Network Availability
Your network is subject to change upon advance written notice. A *network service area* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium. *You* may be balance billed and have to pay the difference between *our* payment and the provider billed amount. Always confirm the network status of all providers prior to treatment.

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

MAJOR MEDICAL EXPENSE 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 MHS.

Benefits for air ambulance services are limited to:

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

Exclusions:
No benefits will be paid for:

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

***You* may be balance billed for covered ambulance services provided by a *non-network* ambulance provider.**

Mental Health and Substance Use 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.

Our behavioral health vendor oversees the delivery of covered behavioral health and substance use disorder services for Ambetter from MHS members. 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 *member*s for the diagnosis and *medically necessary* and active treatment of mental, emotional, 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* behavioral health and substance use vendor utilizes established level of care guidelines and medical necessity criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. *Our* behavioral health and substance use vendor utilizes McKesson's Interqual criteria for mental health determinations and American Society of Addiction Medicine (ASAM) criteria for substance use determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

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

Inpatient

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

Outpatient

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

Autism Spectrum Disorder Benefits
Generally recognized services prescribed in relation to autism spectrum disorder by a *physician* or behavioral health practitioner in a treatment plan recommended by that *physician* or behavioral health practitioner.
For purposes of this section, generally recognized services may include services such as:

- evaluation and assessment services;
- applied behavior analysis;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy;
- habilitation services; or
- medications or nutritional supplements used to address symptoms of autism spectrum disorder.

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

1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    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.*
4. Outpatient physical therapy, occupational therapy and physical therapy.

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*.

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

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

8. Sleep Studies.

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

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

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

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care under the Home Health Care Service Expense Benefit.

Hospice Care Service Expense Benefits
Hospice care benefits are allowable for a *terminally ill member* receiving *medically necessary* care under a *hospice care program*. Covered services include:

1. Room and board in a *hospice* while the *member* is an *inpatient.*
2. Occupational therapy.
3. Speech-language therapy.
4. 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.*
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
6. Counseling the *member* regarding his or her *terminal illness.*
7. *Terminal illness counseling* of the *member's immediate family.*
8. *Bereavement counseling*.

Benefits for *hospice inpatient*, home and outpatient care are available for one continuous period up to one hundred eighty (180) days in a *covered person's* lifetime.

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

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

Respite Care Expense Benefits
Respite care is covered on an 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.

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

a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
b. Daily room and board and nursing services while confined in an *intensive care unit*.
c. *Inpatient* use of an operating, treatment, or recovery room.
d. Outpatient use of an operating, treatment, or recovery room for *surgery.*
e. Services and supplies, including drugs and medicines, which are routinely provided by the *hospital* for use only while *you* are *inpatient.*
f. *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
Covered service expenses are charges:

1. For *surgery* in a *physician's* office or *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* when a *member* suffers an *injury,* after the *member's effective date* of coverage, that results in:
    a. Damage to his or her natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.
11. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.**
12. 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.
13. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the *Schedule of Benefits* for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *contract,* including the *deductible amount* and *percentage* provisions.
14. 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.
15. 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.

16. *Medically necessary services* made by a *physician* in an *urgent care center*, including facility costs and supplies.
17. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
18. Allergy testing.
19. *Medically necessary Telehealth services* subject to the same clinical and utilization review criteria, plan requirements, limitations and *cost sharing* as the same health care services when delivered to an insured in person.
20. For *medically necessary* genetic blood tests.
21. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
22. For *medically necessary* allergy treatment including allergy injection.
23. For hemodialysis, and the charges by a hospital for processing and administration of blood or blood components.

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

Dialysis Services
We cover *medically necessary* acute and chronic dialysis services.

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.

Outpatient Medical Supplies Expense Benefits
Covered expenses for miscellaneous outpatient medical services and supplies are limited to charges:
1. For prosthetic eyes or larynx, breast prosthesis, or basic artificial limbs, including *medically necessary* repairs or replacement to restore or maintain a *member*'s ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per year per *covered person*.
3. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
4. For the rental of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery.

5. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns.
6. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery.

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:

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

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

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

Benefits for repairs and replacement do not include the following:

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

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

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

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 *member's* suffering impotency resulting from disease or injury.

<u>Orthotic devices</u>
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.

Second Medical Opinion
Members are entitled to a second medical opinion under the following conditions:
1. Whenever a surgical procedure is recommended to confirm the need for the procedure;
2. Whenever a serious injury or illness exists; or
3. Whenever *you* find that *you* are not responding to the current treatment plan in a satisfactory manner.

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

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

1. A *prescription drug.*
2. Prescribed, self-administered anticancer medication.
3. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician.*
4. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one (1) *standard reference compendium*; or
    b. The drug is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

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

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 *medical practitioner.*

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

1. For immunization agents, blood, or blood plasma, except when used for preventive care, required by ACA and listed on the formulary.
2. For medication that is to be taken by the *member*, in whole or in part, at the place where it is dispensed.
3. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
4. For a refill dispensed more than 12 months from the date of a *physician's* order.
5. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
6. 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.
7. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
8. For more than a 31-day supply when dispensed in any one prescription or refill or for maintenance drugs up to a 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply network.
9. 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.
10. Off-label use, except as required by law or as expressly approved by *us*.
11. For any drug that *we* identify as therapeutic duplication through the Drug Utilization Review program.
12. Drugs or dosage amounts determined by Ambetter to be ineffective, unproven or unsafe for the indication for which they have been prescribed, regardless of whether the drugs or dosage amounts have been approved by any governmental regulatory body for that use.
13. 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.
14. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
15. 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.
16. Medications used for cosmetic purposes.

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.

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 or a protocol exception for step therapy. 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 or step therapy protocol exception request be granted, *we* will provide coverage of the non-formulary drug for the duration of the prescription, including refills, or of the drug that is the subject of the protocol exception.

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 or step therapy protocol exception request be granted, *we* will provide coverage of the non-formulary drug or the drug that is the subject of the protocol exception 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 three business days following receipt of the request, if the original request was a standard exception, and no later than one business day 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 or step therapy protocol exception request, *we* will provide coverage of the non-formulary drug or the drug that is the subject of the protocol exception 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 or the drug that is the subject of the protocol exception for the duration of the exigency.

Protocol exception for step therapy.

Requests for exceptions to step therapy protocol will be granted if any of the following apply:

(A) A *preceding prescription drug* is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured.

(B) A *preceding prescription drug* is expected to be ineffective, based on both of the following:

(i) The known clinical characteristics of the insured.

(ii) Known characteristics of the *preceding prescription drug*, as found in sound clinical evidence.

(C) The insured has previously received:

(i) a *preceding prescription drug*; or

(ii) another prescription drug that is in the same pharmacologic class or has the same mechanism of action as a *preceding prescription drug*;

and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

(D) Based on clinical appropriateness, a preceding prescription drug is not in the best interest of the *member* because the *member's* use of the *preceding prescription drug* is expected to:

(i) cause a significant barrier to the insured's adherence to or compliance with the *member's* plan of care;

(ii) worsen a comorbid condition of the *member*; or

(iii) decrease the *member's* ability to achieve or maintain reasonable functional ability in performing daily activities.

If the protocol exception request is denied, *we* will provide to the *member* and the *member's* treating health care provider notice of the denial, including a detailed, written explanation of the reason for the denial and the clinical rationale that supports the denial.

We may request a copy of relevant documentation from the *member's* medical record in support of a protocol exception.

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*.

Medically Necessary Vision Services
Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by an Ambetter from MHS 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:

- Visual Therapy
- Any vision services, treatment or materials not specifically listed as a *covered service*.
- Low vision services and hardware for adults
- Non- network care, except when *prior-authorized*.

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 *medically necessary* contacts every calendar year.
    a. Other lens options included are: Fashion and Gradient Tinting, Ultraviolet Protective Coating, Oversized and Glass-Grey #3 Prescription Sunglass lenses, Polycarbonate lenses, Blended Segment lenses, Intermediate Vision lenses, Standard Progressives, Premium Progressives (Varilux®, etc.), Photochromic Glass Lenses, Plastic Photosensitive Lenses (Transitions®), Polarized Lenses, Standard Anti-Reflective (AR) Coating, Premium AR Coating, Ultra AR Coating, and Hi-Index Lenses.
3. One pair of frames per calendar year; and
4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when *prior-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 *prior-authorized*.

Vision Expense Benefits

Routine Vision Adult 19 years of age and older
Routine eye exams, prescriptions eyeglasses, and initial supply of standard contact lenses are covered for

all Ambetter from MHS plans and are managed through *your* vision vendor. For information regarding *your* specific *copayment*s or *deductible amounts* please refer to *your* specific plan information listed in the *Schedule of Benefits*.

You may receive one routine eye exam and eyewear once every calendar year. Eyewear includes **either** one pair of eyeglasses or initial supply of standard contacts.

- **Eyeglasses**
  Covered lenses include single vision, lined bifocal, lined trifocal, or lenticular in glass or plastic. Covered lens add-ons include standard polycarbonate lenses, scratch resistant and anti-reflective coating. If *you* require a more complex prescription lens, contact *your* vision vendor for *prior authorization*. Lens options such as progressive lenses, high index tints and UV coating are not covered.

  For *your* maximum allowance for eyeglass frames please refer to *your* specific plan information listed in the *Schedule of Benefits*. Covered frames are to be selected from *your* vision vendor's frame formulary, offering a wide range of frames that are at no cost to you.

  Should *you* choose to select a frame that is more than *your* maximum benefit, *you* will be financially responsible for the difference.

- **Contact Lenses**
  Coverage includes evaluation, fitting, and initial supply of standard contact lenses. Please refer to *your* specific plan information listed in the *Schedule of Benefits* for *your* maximum allowance for contacts.

For additional information about covered vision services, participating vision vendor providers, call Member Services at 1-877-895-1786.

Dental Benefits – Adults 19 years of age or older

Coverage is provided for adults, age 19 and older, for Preventative and Diagnostic (Basic)—Class 1, and Basic Restorative (Comprehensive)—Class 2 dental services from an *In-Network provider*.

1. Preventative and Diagnostic (Basic)—Class 1 benefits include:
   a. Routine Cleanings;
   b. Oral Exams;
   c. X-rays – bite-wing, full-mouth and panoramic film;
   d. Topical fluoride application;
   e. Palliative Treatment for emergency relief of pain.
2. Minor Restorative (Comprehensive)— Class 2 benefits include:
   a. Minor Restorative – metal and resin based filings;
   b. Endodontics – therapeutic pulpotomy and pulp cap;
   c. Periodontics – scaling, root planning and periodontal maintenance;
   d. Oral Surgery and Extractions
   e. Prosthodontics – relines, rebase, adjustment and repairs.

Please refer to *your Schedule of Benefits* for a detailed list of cost sharing, annual maximum and appropriate service limitations. To see which dental providers are part of the network, please visit Ambetter.mhsindiana.com or call Member Services.

Services not covered for adult Preventative and Diagnostic (Basic)—Class 1, and Minor Restorative (Comprehensive)—Class 2 benefits include:

1. Out of network services;
2. *Dental services* that are not necessary or specifically covered;
3. Hospitalization or other facility charges;
4. *Prescription drugs* dispensed in the dental office;
5. Any dental procedure performed solely as a cosmetic procedure;
6. Charges for dental procedures completed prior to the *member*'s *effective date* of coverage;
7. Anesthesiologists services;
8. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (wear), realignment of teeth, periodontal splinting, and gnathologic recordings;
9. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles;
10. Any artificial material implanted or grafted into soft tissue, surgical removal of implants, and implant procedures;
11. Surgical replacements;
12. Sinus augmentation;
13. Surgical appliance removal;
14. Intraoral placement of a fixation device;
15. Oral hygiene instruction, tobacco counseling, nutritional counseling;
16. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture;
17. Any oral surgery that includes surgical endodontics (apicoectomy and retrograde filling);
18. Root canal therapy;
19. Removable unilateral dentures;
20. Temporary procedures;
21. Splinting;
22. Temporal Mandibular Joint disorder (TMJ) appliances, therapy, films and arthorograms;
23. Lab tests including, but not limited to viral culture, saliva diagnostics, caries testing;
24. Consultations by the treating provider and office visits;
25. Initial installation of implants, full or partial dentures or fixed bridgework to replace a tooth or teeth extracted prior to the *member*'s *effective date*;
26. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
27. Veneers (bonding of coverings to the teeth);
28. Orthodontic treatment procedures;
29. Corrections to congenital conditions, other than for congenital missing teeth;
30. Athletic mouth guards;
31. Retreatment or additional treatment necessary to correct or relieve the results of previous treatment;
32. Space maintainers for anyone 19 years of age or older.

Other Dental Services

Anesthesia and *hospital* charges for dental care, for a *member* less than 19 years of age or a *member* who is physically or mentally disabled, are covered if the *member* requires dental treatment to be given in a *hospital* or outpatient ambulatory surgical facility. The Indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the *member's* condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Preventive Care Expense Benefits

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

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. Examples of these services are screenings for breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, prostate specific antigen testing and screenings for child and adult obesity.
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual.
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.
5. Covers without *cost sharing:*
    a. Screening for *tobacco use*; and
    b. For those who *use tobacco* products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
        i. Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without *prior authorization*; and
        ii. All Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without *prior authorization*.

Benefits for preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any *deductible amounts, cost sharing percentage* provisions, and *copayment amounts* under the *contract* when the services are provided by a *network provider.* If a service is considered diagnostic or non-preventive care, *your* "plan" *copayment*, *coinsurance* and *deductible* will apply. It's important to know what type of service you're getting. If a diagnostic or non-preventive service is performed during the same healthcare visit as a preventive service, *you* may have *copayment* and *coinsurance* charges.

Mammography

Covered service expenses for routine screenings for breast cancer shall include screenings at the following intervals: one (1) Baseline breast cancer screening mammography for a *covered person* between the ages of thirty-five (35) and forty (40) years. If the *covered person* is less than forty (40) years of age and at risk,

one (1) breast cancer screening mammography performed every year. If the *covered person* is at least forty (40) years of age, one (1) breast cancer screening mammography every year and any additional mammography views that are required for proper evaluation.

Prostate Specific Antigen Testing
Covered service expenses include "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for a *covered person* who is at least fifty (50) years of age; and at least once annually for a *covered person* who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Colorectal Cancer Examinations and Laboratory Tests
Covered service expenses include "colorectal cancer tests" for any non-symptomatic *covered person*, in accordance with the current American Cancer Society guidelines. *Covered service* includes tests for *covered persons* who are at least fifty (50) years of age; or less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

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

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

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

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

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).

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 an enrollee 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.

Clinical Trial Coverage

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

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

Phase I and II clinical trials must meet the following requirements:

- Phase I and II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and
- The insured is enrolled in the clinical trial. This section shall not apply to insured's who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

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

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

- A qualified non-governmental research entity that meets the criteria for NIH Center support grant eligibility.

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

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

Transplant Expense Benefits
Covered Services For Transplant Service Expenses:
If *we* determine that a *member* is an appropriate candidate for a *medically necessary* transplant, medical service expense benefits will be provided for:

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

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

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

Ancillary "Center Of Excellence" Service Benefits:
A *member* may obtain services in connection with a *medically necessary* transplant from any *physician*. However, if a *medically necessary* transplant is performed in a *Center of Excellence:*

1. *Covered service expenses* for the *medically necessary* transplant will include the acquisition cost of the organ or bone marrow.
2. *We* will pay a maximum amount shown in the *Schedule of Benefits* for the following services:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence.*
    b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence. We* will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

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

1. For search and testing in order to locate a suitable donor.
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *medically necessary* transplant occurs.
3. For animal to human transplants.

4. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
6. To keep a donor alive for the transplant operation.
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
8. Related to transplants not included under this provision as a *medically necessary* transplant.
9. For a *medically necessary* transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"FDA"*) regulation, regardless of whether the trial is subject to *FDA* oversight.
10. Left Ventricular Artificial Devices (LVAD) when used as destination.
11. Total artificial heart is not covered (even though it is a bridge to transplant).

Limitations on Transplant Service Expense Benefits:
In addition to the exclusions and limitations specified elsewhere in this section, if a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

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 denied. A *non-network provider* can balance bill *you* for these services. .

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.*

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

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

Although health care services may be or have been provided to *you* at a health care facility that is a member of the provider network used by Ambetter, other professional services may be or have been provided at or through the facility by *physicians* and other *medical practitioners* who are not members of that network. *You* may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by Ambetter.

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 by a member of a *member's immediate family.*
4. Any services not identified and included as *covered service expenses* under the *contract*. *You* will be fully responsible for payment for any services that are not *covered service expenses.*

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

1. Administered or ordered by a *physician* or *medical practitioner;* 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*, bariatric Surgery and weight loss programs, except as specifically covered in the Preventive Services section of the *contract.*
4. For the reversal of sterilization and the reversal of vasectomies.
5. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
6. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Medical and Surgical Expense Benefits provisions.
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 expense benefits.
12. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect in a child.
13. For Mental health exams and services involving: 1) Services for psychological testing associated with the evaluation and diagnosis of learning disabilities 2) Marriage counseling 3) Pre-marital counseling 4) Court-ordered care or testing, or required as a condition of parole or probation 5) Testing of aptitude, ability, intelligence or interest 6) Evaluation for the purpose of maintaining employment inpatient confinement or inpatient mental health services received in a residential treatment facility unless associated with chemical or alcohol dependency in a nonmedical transitional residential recovery setting.
14. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.

15. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
16. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
17. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
18. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.
19. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
20. For hearing aids, except as expressly provided in this *contract*.
21. 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.
22. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of (90) consecutive days.
23. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
24. As a result of:
    a. An *injury* or *illness* caused by any act of declared or undeclared war.
    b. The *member* taking part in a riot.
    c. The *member's* commission of a felony, whether or not charged.
25. For or related to surrogate parenting.
26. For or related to treatment of hyperhidrosis (excessive sweating).
27. For fetal reduction surgery.
28. Except as specifically identified as a *covered service expense* under the *contract*, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
29. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or Semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).
30. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
31. 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.

32. For the following miscellaneous items: Artificial Insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-*covered services*; 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, except for treatment of diabetes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements unless *medically necessary* and specifically described in this *contract*; pre-marital lab work; processing fees; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the *service area*; sclerotherapy for varicose veins; treatment of spider veins; transportation expenses, unless specifically described in this *contract*.
33. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
34. For court ordered testing or care unless *medically necessary* or is required by law.
35. For a *member's illness* or *injury* which is caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*.

TERMINATION

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date *we* receive a request from *you* to terminate this *contract,* or any later date stated in *your* request, or if *you* are enrolled through the Health Insurance Marketplace, the date of termination that the Health Insurance Marketplace provides *us* upon *your* request of cancellation to the Health Insurance Marketplace.
3. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision.
4. The date of *your* death, if this *contract* is an Individual Plan.
5. For a dependent child reaching the limiting age of 26, coverage under this *contract*, for a dependent child, will terminate the thirty-first (31st) of December the year the dependent turns 26 years of age.
6. The date a *member's* eligibility for coverage under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.
7. The date a *member's* eligibility for coverage under this *contract* ceases as determined by the Health Insurance Marketplace.

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 Marketplace, or if an off-Marketplace *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.

Reinstatement
For coverage purchased outside the Health Insurance Marketplace, *we* will reinstate a *contract* when it is erroneously terminated or cancelled. The reinstatement will result in restoration of the enrollment with no break in coverage. For coverage purchased via the Health Insurance Marketplace, the Health Insurance Marketplace should be contacted for reinstatement.

Discontinuance
90-Day Notice: If *we* discontinue offering and refuse to renew all contracts issued on this form, 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.

SUBROGATION AND RIGHT OF REIMBURSEMENT

As used herein, the term "*third party*" means any party that is, or may be, or is claimed to be responsible for *injuries* or *illness* to a *member*. Such *injuries* or *illness* are referred to as "*third party injuries*." *Third party* includes any parties actually, possibly or potentially responsible for payment of expenses associated with the care or treatment of *third party injuries.*

If this plan provides benefits under this *contract* to a *member* for expenses incurred due to *third party injuries,* then Celtic retains the right to repayment of the full cost of all benefits provided by this plan on behalf of the *member* that are associated with the *third party injuries.* Celtic's rights of recovery apply to any recoveries made by or on behalf of the *member* from any sources, including but not limited to:

- Payments made by a *third party* or any insurance company on behalf of the *third party;*
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and
- Any other payments from a source intended to compensate a *member* for *third party injuries*.

By accepting benefits under this plan, the *member* specifically acknowledges Celtic's right of subrogation. When this plan provides health care benefits for expenses incurred due to *third party injuries*, Celtic shall be subrogated to the *member's* rights of recovery against any party to the extent of the full cost of all benefits provided by this plan. Celtic may proceed against any party with or without the *member's* consent.

By accepting benefits under this plan, the *member* also specifically acknowledges Celtic's right of reimbursement. This right of reimbursement attaches when this plan has provided health care benefits for expenses incurred due to *third party injuries* and the *member* or the *member's* representative has recovered any amounts from any source. By providing any benefit under this plan, Celtic is granted an assignment of the proceeds of any settlement, judgment or other payment received by *you* to the extent of the full cost of all benefits provided by this plan. Celtic's right of reimbursement is cumulative with and not exclusive of Celtic's subrogation right and Celtic may choose to exercise either or both rights of recovery.

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

1. To fully cooperate with *us* in order to obtain information about the *loss* and its cause.
2. To immediately inform *us* in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.
3. To include the amount of benefits paid by *us* on behalf of a *member* in any claim made against any *third party*.
4. To give Celtic a first-priority lien on any recovery, settlement or judgment or other sources of compensation which may be had from any party to the extent of the full cost of all benefits associated with *third party injuries* provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
5. To pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due Celtic as reimbursement for the full cost of all benefits associated with *third party injuries* provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement).
6. That *we*:
    a. Will have a lien on all money received by a *member* in connection with the *loss* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.

    d. Are subrogated to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert that subrogation right independently of the *member*.
7. To take no action that prejudices *our* reimbursement and subrogation rights including, but not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan.
8. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights.
9. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
10. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
11. That *we* may reduce other benefits under the *contract* by the amounts a *member* has agreed to reimburse *us*.

We will not pay attorney fees or costs associated with the *member's* claim or lawsuit. In the event *you* or *your* representative fail to cooperate with Celtic, *you* shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by Celtic in obtaining repayment.

If a dispute arises as to the amount a *member* must reimburse *us*, the *member* (or the guardian, legal representatives, estate, or heirs of the *member*) agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by *us* until the dispute is resolved.

Celtic may recover full cost of all benefits paid by this plan without regard to any claim of fault on *your* part, whether by comparative negligence or otherwise. In the event *you* or *your* representative fail to cooperate with Celtic, *you* shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by Celtic in obtaining repayment.

COORDINATION OF BENEFITS

Ambetter coordinates benefits with other payers when a *member* is covered by two or more health benefit plans. Coordination of Benefits (COB) is the industry standard practice used to share the cost of care between two or more carriers when a *member* is covered by more than one health benefit plan.

It is a contractual provision of a majority of health benefit contracts. Ambetter complies with Federal and state regulations for COB and follows COB guidelines published by National Association of Insurance Commissioners (NAIC).

Under COB, the benefits of one plan are determined to be primary and are first applied to the cost of care. After considering what has been covered by the primary plan, the secondary plan may cover the cost of care up to the fully allowed expense according to the plan's payment guidelines. Ambetter Claims COB and Recovery Unit procedures are designed to avoid payment in excess of allowable expense while also making sure claims are processed both accurately and timely.

"Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid. . When Medicare is the Primary Plan, Medicare's allowable expense is the allowable expense when *we* are paying claims as the Secondary Plan.

"Plan" is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

1. Group and nongroup insurance contracts and subscriber contracts;
2. Uninsured arrangements of group or group-type coverage;
3. Group and nongroup coverage through closed panel plans;
4. Group-type contracts;
5. The Medicare care components of long-term care contracts, such as skilled nursing care;
6. The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts; and
7. Medicare or other governmental benefits, as permitted by law, except as provided with a state plan under a government plan whose benefits are in excess of those of a nongovernmental plan. The part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

The term "Plan" does not include:

1. Hospital indemnity coverage benefits or other fixed indemnity coverage;
2. Accident only coverage;
3. Specified disease or specified accident coverage;
4. Limited benefit health coverage;
5. Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
6. A state plan under Medicaid or a government plan that, by law, provides benefits that are in excess of those of any: (a) private insurance plans; or (b) other nongovernmental plan.
7. Medicare supplement policies.

"Primary plan" is one whose benefits must be determined without taking the existence of any other plan

into consideration. A plan is primary if either:

1. The plan has no order of benefits rules or its rules differ from those required by regulation; or
2. All plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

"Secondary plan" is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

Order of Benefit Determination Rules
When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary plan pays or provides its benefits as if the Secondary plan or plans did not exist. A Plan may consider benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

2. If the other plan does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:

    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

3. Each Plan determines its order of benefits using the first of the following rules that apply:

    a. **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
    b. **Dependent Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, when a dependent child is covered by more than on Plan the order of benefits is determined as follows:
        i. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the calendar year (excluding year of birth) shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary.

        ii. If a child is covered by both parents' plans and the parents are separated or divorced, whether or not they have ever been married:

A. If a court order or decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse is the primary plan. This rule applies to the plan years commencing after the Plan is given notice of the court decree;

B. If a court order or decree states that both parents are responsible for or orders joint custody without considering for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (i) above shall determine the order of benefits.

C. If there is no court order or decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

1) The Plan covering the Custodial parent;
2) The Plan covering the spouse of the Custodial parent;
3) The Plan covering the non-custodial parent; and then
4) The Plan covering the spouse of the non-custodial parent.

iii. For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of subparagraph i or ii above shall determine the order of benefits as if those individuals were the parents of the child.

4. **Active Employee or Retired or Laid-off Employee**. If the person receiving services is covered under one plan as an active employee (i.e., not laid-off or retired), or as the *spouse* or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the *spouse* or child of such a laid-off or retired employee, the plan that covers such person as an active employee or *spouse* or child of an active employee will be primary. If the *other plan* does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored. This rule does not apply if the rule 3(a) can determine the order of benefits.

5. **COBRA or State Continuation Coverage**. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 3(a) can determine the order of benefits.

6. **Longer or Shorter Length of Coverage**. The Plan that covered the person longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

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

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Ambetter's maximum available benefit

for each Covered Service. Also, the amount Ambetter pays will not be more than the amount Ambetter would pay if Ambetter were primary. As each claim is submitted, Ambetter will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period. When this plan is secondary as a result of one of *our member*s being a Medicare beneficiary, see above definition for Allowable Expense, as *we* will reduce *our* benefits up to Medicare's allowable.

*Member*s may no longer be eligible to receive a premium subsidy for the Health Insurance Marketplace plan once Medicare coverage becomes effective.

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

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 90 days of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than one year late will not be accepted, unless *you* or *your* covered *dependent member* had no legal capacity to submit such proof during that year.

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

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

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

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

Time for Payment of Claims
Benefits will be paid within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by *you* or a provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If *we* have not received the information *we* need to process a claim, *we* will ask for the additional information necessary to complete the claim. *You* will receive a copy of that request for additional information. In those cases, *we* cannot complete the processing of the claim until the additional information requested has been received. *We* will make *our* request for additional information within 30 days of *our* initial receipt of the claim and will complete *our* processing of the claim within 15 days after *our* receipt of all requested information.

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 also 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.

Medicaid Reimbursement
The amount provided or payable under this *contract* will not be changed or limited for reason of a *member* being eligible for coverage under the Medicaid program of the state in which he or she lives.

We will pay the benefits of this *contract* to the state if:
1. A *member* is eligible for coverage under his or her state's Medicaid program; and
2. *We* receive proper *proof of loss* and notice that payment has been made for *covered service expenses* under that program.

Our payment to the state will be limited to the amount payable under this *contract* for the *covered service expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

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

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

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

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

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

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.*

Notwithstanding the foregoing, *you* may specifically authorize, in writing, the payment of benefits that *we* have determined to be due and payable directly to any *hospital, provider*, or other person who provided *you* with any covered service and *we* will honor this specific direction and make such payment directly to the designated provider of the covered service.

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 GRIEVANCE, INTERNAL APPEALS, AND EXTERNAL APPEALS PROCEDURES

INTERNAL PROCEDURES:

Applicability/Eligibility

An Eligible grievant is:

1. A covered individual under the *contract*, also described as the claimant*;*
2. Person authorized to act on behalf of the claimant. **Note:** Written authorization is not required; however, if received, *we* will accept any written expression of authorization without requiring specific form, language, or format;
3. In the event the claimant is unable to give consent: a *spouse*, family member, or the treating provider; or
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given authorization to represent the claimant.

Ombudsman

The aim of the Ombudsman Program is to provide Ambetter from MHS *members* free and easy access to an independent party which will investigate the *member's* concern(s), provide member education, and help *members* contact the right people for assistance within the Health Insurance Marketplace and Ambetter programs.

1. Program is administered and managed by a non-profit, community-based independent organization.
2. If *you* are disappointed with the actions that the health plan has taken *you* have the opportunity to discuss this with the Ombudsman.
3. *You* may contact the Ombudsman organization directly at 1-877-647-5326 (toll free).

Grievances

A *grievance* is defined, in accordance with IC 27-8-28-6, as dissatisfaction expressed by the covered individual in regards to:

- A determination that a service or benefit is not deemed appropriate or *medically necessary,*
- A determination that a service or benefit is deemed to by experimental or investigational in nature,
- The availability of providers,
- The handling or payment of claims for services or benefits as covered in this *contract*,
- Matters pertaining to the contractual relationship between the covered individual and the health plan, or
- An insurer's decision to rescind the *contract*.

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

To file a *grievance*, call Member Services at 1-877-687-1182 (TDD/TTY) 1-877-941-9232. *You* can also write a letter and mail or fax *your grievance* to MHS at 1-866-714-7993. Be sure to include:

- *Your* first and last name.
- *Your* Member ID number.
- *Your* address and telephone number.
- What *you* are unhappy with.
- Any supporting documentation.

- What *you* would like to have happen (desired outcome).

The 180 calendar days start on the date of the situation *you* are not satisfied with. *We* would like for *you* to contact *us* right away so *we* can help *you* with *your* concern as soon as *we* can. A *grievance* may be filed in writing by mail at the address below or file the *grievance* in person at:

Grievances and Appeals Coordinator
550 North Meridian Street
Suite 101
Indianapolis, IN 46204

Claimants have the right to submit a *grievance* in written or oral format to the health plan. The claimant may provide comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process. A *grievance* may be filed by calling *our* toll-free Member Services number at 1-877-687-1182 (TDD/TYY 1-800-743-3333). *Member*s may request assistance in filing a *grievance* with *our* health plan.

Grievances will be promptly investigated and presented to the internal *grievance* committee. 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 a *grievance*.

Process and Resolution Timeframes

1. *We* will offer an acknowledgement of the *grievance* within 3 (three) business days of initial receipt of the *grievance*, either orally or in written form, to the covered individual. 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*.
   (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.
2. *Grievance*s regarding quality of care, quality of service, or *rescission* of coverage will be resolved within 20 business days of receipt of all necessary information. The time period may be extended for an additional 10 business days if *we* provide the claimant and the claimant's authorized representative, if applicable, written notification of the following within the first 20 business 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.
3. All other *grievance*s will be resolved and *we* will notify the claimant in writing with the appeal decision within 5 (five) business days after completing an investigation.

A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant'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 claimant will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer.

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 claimant and *us* by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as the *claimant*'s health condition requires but not more than 48 hours after receipt of the *grievance*.

Due to the 48-hour resolution timeframe, the standard requirements for notification and acknowledgement do not apply to *expedited grievances*.

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

Written Grievance Response from Us

Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial of the benefit(s) or service(s), determination of the benefit(s) or service(s), decision on an issue, or initiation of disenrollment.

The health plan's written decision to the grievant must include:

1. A clear statement of the decision;
2. The disposition of and the specific reason or reasons, including policies and procedures that apply, for the decision;
3. Any corrective action taken on the *grievance*;
4. Notice of the individual's right to appeal the *grievance* decision; and
5. Correspondence information should the covered individual choose to appeal the decision.

INTERNAL APPEALS:

A *member* or Authorized Representative may appeal when he or she has a concern regarding a claim denial or other action by Ambetter from MHS under the *contract* and wishes to have it reviewed. There is an Internal Appeal, as well as additional voluntary Appeal level available. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section.

An Internal Appeal is a form of *grievance.* The term *appeal* is defined as a request for a review of an action of an Adverse Determination. An Adverse Determination is a decision that was made, based on review of information that was provided, to deny, reduce, modify, or terminate an admission, continued *inpatient* stay, or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care, or effectiveness. An Internal Appeal is reviewed as either a Standard/Non-expedited Internal Appeal or as an Expedited Internal Appeal. If a decision on an Appeal is required immediately due to *your* health needs, an expedited Appeal may be requested. A *member*, or a *member*'s authorized representative, may request an Expedited External Review at the same time as they are requesting an Expedited Internal Appeal. The following outlines the process for each.

Appeals can be initiated through either written or verbal request. A written request may be sent via facsimile to 855-685-6513 or e-mailed to: appeals@mhsindiana.com or mailed to Ambetter from MHS at:

Ambetter from MHS Grievance and Appeals Coordinator
550 North Meridian Street
Suite 101
Indianapolis, IN 46204

Verbal requests can be made by calling *us* at 1-877-687-1182 (TDD/TYY 1-800-743-3333). An Internal Appeal submitted by phone or in person will be received by a Member Services Representative who will write a summary of the Internal Appeal request. *You* may request a copy of this summary to be mailed to *you.* An acknowledgement letter, of the appeal, will be sent within five (5) business days of receipt of the Internal Appeal.

Internal Appeals, including Expedited Appeals, must be pursued within 180 days of receipt of the original determination. If *your* request for Appeal is not received within this time period, *you* will not be able to continue to pursue the Appeal process and may jeopardize *your* ability to pursue the matter in any forum. *We* will send *you* written acknowledgement letter within five (5) business day of receipt of *your* appeal. If *you* or *your* treating provider determines that *your* health could be jeopardized by waiting for a decision under the regular Appeal process, *you* or *your* provider may specifically request an Expedited Appeal. Please see Expedited Appeals later in this section for more information.

INTERNAL APPEAL CONTINUATION OF CARE
If *you* are still receiving the services that are under appeal, and the services are *covered services*, the services may continue until a decision is made on the Internal Appeal. Ambetter from MHS will pay for the cost of continued services regardless of the outcome minus any applicable *copays* or *deductible amounts.* This continuation of coverage or treatment applies only to those services which, at the time of the service initiation, were approved by Ambetter from MHS and were not terminated because benefit coverage for the service was exhausted.

INTERNAL APPEAL REVIEW
The content of the Internal Appeal request including all clinical care aspects involved will be fully reviewed and documented. *You* or *your* authorized representative will have the right to submit comments, documentation, records, and other information relevant to the Internal Appeal in person or in writing. *You* have the right to appear in person before the committee reviewing the appeal, or to provide appropriate communication and documentation to the committee. A provider or other appropriate clinical peer of a same-or-similar specialty, who was not involved in the initial decision, will evaluate medical necessity decision of a final determination. Ambetter from MHS will review, resolve and provide the *member* with written or electronic notification of the appeal decision as quickly as the *member's* health condition requires but no later than:

Pre-service appeals
- 30 calendar days (or per state timeframes if more stringent)

Post-service appeals
- 60 calendar days (or per state timeframes if more stringent)

from notification from the claimant of the appeal. *We* will notify *you* of the review decision within 5 business days of completion of the investigation.

Internal Appeal Committee
Upon receipt of an appeal, *your* appeal will be assigned to one or more individuals to review. The committee will include individuals that:
- Have knowledge of the medical condition, procedure, or treatment that is under issue;
- Are licensed in the same profession or clinical background as the provider that is requesting the proposed service(s) or benefit(s);

- Are not involved or have not been involved in the matter which created the appeal and were not involved in the initial appeal investigation of the matter; and,
- Do not have a direct business or personal relationship with the *member* or the provider who recommended the service(s) or benefit(s).

INTERNAL APPEAL DETERMINATION NOTIFICATION

- The Plan must resolve a **pre-service appeal** and provide the *member* with written or electronic notification of the decision within 30 calendar days of the pre-service appeal request (or per state regulation timeframes, if more stringent).
- **Post-service appeal** resolution and notification must be made in writing or electronically within 60 calendar days of receipt of the appeal request (or per state regulation timeframes, if more stringent).

The written notification of the resolution of the standard Internal Appeal will include:

- A clear statement outlining the decision reached by the health plan about *your* appeal.
- The specific medical and scientific reasons, including policies and procedures used, in coming to the decision.
- Criteria or clinical guidelines or standards of care used in making the determination.
- The right to receive a copy of the criteria or all information in the appeal file, free of charge.
- A list of titles and qualifications, including specialties, of individuals participating in the appeal review.
- The *member*'s right to obtain an independent External Review through the IRO including the timeframe for filing.
- Contact information, including address and telephone number, to obtain additional information on the appeal or for filing an external review.

If the Internal Appeal request was not over-turned or resolved to *you* or *your* authorized representative's satisfaction, an External Review by an Independent Review Organization (IRO) may be requested. Information for pursuing an External Review is included in the Internal Appeal determination letter. If *you* do not receive a response to *your* Internal Appeal within the timeframes outlined, or those that are mutually agreed upon, *your* Appeal will be deemed to be decided in *your* favor.

EXPEDITED INTERNAL APPEAL

If a decision on an Appeal is required urgently (within 48 hours) due to *your* health needs which cannot wait with the standard resolution time, an Expedited Internal Appeal may be requested. An Expedited Internal Appeal may be requested if:

- *You* are currently receiving or are prescribed treatment for a medical condition; and *your* treating provider believes the application of regular Appeal timeframes on a pre-service or concurrent care claim could seriously jeopardize *your* life, overall health or ability to regain maximum function, or would subject *you* to severe and intolerable pain; or
- The Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an *emergency* basis where *you* have not been discharged. Expedited appeals are available to *members* for any urgent care requests. Expedited appeal decisions and notification will be made as expeditiously as the *member's* medical condition requires, but no later than 72 hours after the appeal request (or per state timeframes if more stringent). Expedited appeals are not available for post-service requests.
- The timeframe for disposition of standard appeals may be extended for up to 14 calendar days and 48 hours for expedited appeals if the *member*, the *member*'s authorized representative, or health care practitioner acting on behalf of the *member* requests the extension or voluntarily agrees to the extension. For any extension not requested by the *member*, Marketplace Health Plans will give the *member* written notice of the reason for the delay and obtain the *member*'s consent for the

extension. If the *member* does not consent to the extension, the appeal will be decided with the information available before the timeframe expires. An appeal may be withdrawn by written request from the person who filed the appeal.

EXPEDITED INTERNAL APPEAL SUBMISSION and PROCESS
An Expedited Internal Appeal is requested, handled, and processed in the same manner as a Standard Internal Appeal. For an Expedited Internal Appeal in which *you* are currently an inpatient in a *hospital*, a provider may act as *your* authorized representative without a signed written consent from *you*.

If *you* are currently receiving covered services, *you* may continue to receive services at the expense of Ambetter from MHS through the completion of the Expedited Internal Appeal process if the Expedited Internal Appeal is filed timely and the service was previously *authorize*d by Ambetter from MHS.

External Review
If *you,* or *your* authorized representative, are not satisfied with the final outcome of the Internal Appeal, an External Review by an Independent Review Organization may be requested. *You*, or *your* authorized representative, can request an External Review when the Appeal is of *adverse benefit determinations* based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. Filing an External Review will **not** affect *your* healthcare services. *We* want to know *your* concerns so *we* can improve *our* services.

An external review decision is binding on *us*. *We* will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility
The External Review Appeals procedures apply to:
1. Any *hospital* or medical policy or certificate; excluding accident only or disability income only insurance.
2. The request for an IRO must be submitted within one hundred twenty (120) calendar days from the date of the notice of action regarding their expedited or standard appeal (or per state timeframes if more stringent). The request must be submitted within ten (10) calendar days of the date of the notice of resolution, if the *member* wishes to have continuation of benefits during the external independent review. The Plan will assist the *member* or their representative with filing the appeal, as requested.
3. Claimants may request an expedited external review from an Independent Review Organization (IRO) should the issue at question be related to disease, illness, injury, health condition, or a disability that the decision would seriously jeopardize the individual's health, life, or ability to reach or maintain maximum function.

External review is available for *appeals* 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
We have fifteen (15) business days following receipt of the request to provide a final and binding decision made by the IRO to the individual. The decision from the IRO will be based upon information from the

insurer, the insured individual or authorized representative, the treating health care provider, and any other information the IRO deems appropriate and relevant to the issue.

The IRO will also provide notification to the individual and the health plan within 72 hours of completion of their review. The IRO will include:

- A clear statement of the binding decision;
- Standards used in the decision, including objective clinical evidence; and,
- Any applicable terms or eligibility of the individual's insurance policy.

Expedited External Review Process
An expedited external review may be requested by the *member* should the issue be thought to seriously jeopardize the individual's health or life, or ability to maintain or achieve maximum function. An expedited review will follow the same process as outline above. For an expedited external review, both the determination and notification to the *member* and *covered person* must be provided within 72 hours of the claim being filed.

Member Rights & Responsibilities When Requesting an External Review
You have the right to request an external review provided by an Independent Review Organization (IRO). *We* will cover all costs associated with an external review. *You* shall not face any type of retaliation from *us* for filing an external review. *You* may continue to utilize any other covered benefits associated with *your* health insurance *contract*. *You* may also submit any new or additional information as a part of the external review process for further consideration of *your* appeal. *You* are expected to cooperate with any requests from the IRO, such as providing any requested medical information or signing releases for additional medical records. *We* will also fully cooperate with the IRO for any such requests of information related to the appeal, or *your* care provided by *us.*

You may also request *your* case information from the IRO to better understand the effect of the determination and what response *you* should expect from *us.*

Questions regarding *your contract* or coverage should be directed to:

Ambetter from MHS
550 North Meridian Street, Suite 101
Indianapolis, IN 46204
1-877-687-1182 (TDD/TYY 1-800-743-3333)

If *you* need the assistance of the governmental agency that regulates insurance; or have a complaint *you* have been unable to resolve with *your* insurer *you* may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2385
Complaints can be filed electronically at www.in.gov/idoi.

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

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

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

Statement of Non-Discrimination

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

Ambetter from MHS:

- 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 MHS at 1-877-687-1182 (TTY/TDD 1-800-743-3333).

If you believe that Ambetter from MHS 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 MHS Grievance and Appeals Department, PO Box 441567, Indianapolis, IN 46244, 1-877-687-1182 (TTY/TDD 1-800-743-3333), Fax 1-866-714-7993. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from MHS 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*.

Declaración de no discriminación

Ambetter de MHS cumple con las leyes de derechos civiles federales aplicables y no discrimina basándose en la raza, color, origen nacional, edad, discapacidad, o sexo. Ambetter de MHS no excluye personas o las trata de manera diferente debido a su raza, color, origen nacional, edad, discapacidad, o sexo.

Ambetter de MHS:

- Proporciona ayuda y servicios gratuitos a las personas con discapacidad para que se comuniquen eficazmente con nosotros, tales como:
    - Intérpretes calificados de lenguaje por señas
    - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Proporciona servicios de idiomas a las personas cuyo lenguaje primario no es el inglés, tales como:
    - Intérpretes calificados
    - Información escrita en otros idiomas

Si necesita estos servicios, comuníquese con Ambetter de MHS a 1-877-687-1182 (TTY/TDD 1-800-743-3333).

Si considera que Ambetter de MHS no le ha proporcionado estos servicios, o en cierto modo le ha discriminado debido a su raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja ante: Ambetter from MHS Grievance and Appeals Department, PO Box 441567, Indianapolis, IN 46244, 1-877-687-1182 (TTY/TDD 1-800-743-3333), Fax 1-866-714-7993. Usted puede presentar una queja por correo, fax, o correo electrónico. Si necesita ayuda para presentar una queja, Ambetter de MHS está disponible para brindarle ayuda. También puede presentar una queja de violación a sus derechos civiles ante la Oficina de derechos civiles del Departamento de Salud y Servicios Humanos de Estados Unidos (U.S. Department of Health and Human Services), en forma electrónica a través del portal de quejas de la Oficina de derechos civiles, disponible en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, o por correo o vía telefónica llamando al: 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).

Los formularios de queja están disponibles en *http://www.hhs.gov/ocr/office/file/index.html*.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de MHS, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-687-1182 (TTY/TDD 1-800-743-3333).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from MHS 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-877-687-1182 (TTY/TDD 1-800-743-3333)。
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from MHS hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-687-1182 (TTY/TDD 1-800-743-3333) an.
Pennsylvania Dutch:	Vann du, adda ebbah's du am helfa bisht, ennichi questions hott veyyich Ambetter from MHS, dann hosht du's recht fa hilf greeya adda may aus finna diveyya in dei shprohch un's kosht nix. Fa shvetza mitt ebbah diveyya, kawl 1-877-687-1182 (TTY/TDD 1-800-743-3333).
Burmese:	သင် သို့မဟုတ် သင်မှကူညီနေသူတစ်ဦးဦးတွင် Ambetter from MHS အကြောင်း မေးစရာများရှိပါက အခမဲ့အကူအညီ ရယူပိုင်ခွင့်နှင့် သင်၏ဘာသာစကားဖြင့် အချက်အလက်များကို အခမဲ့ရယူပိုင်ခွင့် ရှိပါသည်။ စကားပြန်တစ်ဦးနှင့် စကားပြောဆိုရန် 1-877-687-1182 (TTY/TDD 1-800-743-3333) ကို ဖုန်းဆက်ပါ။
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from MHS، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-687-1182 (TTY/TDD 1-800-743-3333).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from MHS 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-687-1182 (TTY/TDD 1-800-743-3333)로 전화하십시오.
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from MHS, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-687-1182 (TTY/TDD 1-800-743-3333).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from MHS, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-877-687-1182 (TTY/TDD 1-800-743-3333).
Japanese:	Ambetter from MHS について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-877-687-1182 (TTY/TDD 1-800-743-3333) までお電話ください。
Dutch:	Als u of iemand die u helpt vragen heeft over Ambetter from MHS, hebt u recht op gratis hulp en informatie in uw taal. Bel 1-877 687-1182 (TTY/TDD (teksttelefoon) 1-800 743-3333) om met een tolk te spreken.
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from MHS, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-687-1182 (TTY/TDD 1-800-743-3333).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from MHS вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-877-687-1182 (TTY/TDD 1-800-743-3333).
Punjabi:	ਜੇ ਤੁਹਾਡੇ, ਜਾਂ ਤੁਹਾਡੀ ਮਦਦ ਲੈ ਰਹੇ ਕਿਸੇ ਵਿਅਕਤੀ ਦੇ ਮਨ ਵਿਚ Ambetter from MHS ਦੇ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮੁਫਤ ਮਦਦ ਲੈਣ ਦਾ ਪੂਰਾ ਹੱਕ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ 1-877-687-1182 (TTY/TDD 1-800-743-3333) 'ਤੇ ਕਾਲ ਕਰੋ।
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from MHS 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 1-877-687-1182 (TTY/TDD 1-800-743-3333) पर कॉल करें।