

CELTIC INSURANCE COMPANY

Home Office: 200 East Randolph
Chicago, Illinois 60601
For Inquiries or Complaints: 1-800-714-4658

Major Medical Expense Insurance Policy

This *policy* is in effect from the effective date stated on the *Schedule of Benefits* through 12-31-2020.

In this *policy*, "*you*" or "*your*" will refer to the *covered person* or any dependents enrolled in this *policy*, and "*we*," "*our*," or "*us*" will refer to Celtic Insurance Company.

AGREEMENT AND CONSIDERATION

We issued this *policy* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is made a part of the *policy*. *We* will pay benefits to *you*, the *covered person*, for covered *loss* due to *illness* or *bodily injury* as outlined in this *policy*. Benefits are subject to *policy* definitions, provisions, limitations and exclusions.

Please read the copy of the application attached to this *policy*. Carefully check the application and write to the company at the address listed at the top of this page within 10 days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. This application is a part of the *policy* and the *policy* was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

GUARANTEED RENEWABLE

Annually, *we* must file this product, the cost share and the rates associated with it for approval. Guaranteed renewable means that *your* plan will be renewed into the subsequent year's approved product on the anniversary date unless terminated earlier in accordance with *contract* terms. *You* may keep this *contract* (or the new contract *you* are mapped to for the following year) in force by timely payment of the required premiums. In most cases *you* will be moved to a new contract each year, however, *we* may decide not to renew the *contract* as of the renewal date if: (1) *we* decide not to renew all contracts issued on this form, with a new contract at the same metal level with a similar type and level of benefits, to residents of the state where *you* then live; (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 *contract* 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 in excess of \$300 owed to *us* and not the provider of services within 90 days after the date of the procedure; (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.

From time to time, *we* will change the rate table used for this *policy* form. Each premium will be based on the rate table in effect on that premium's due date. The policy plan, and age of *covered persons*, type and level of benefits, and place of residence on the premium due date are some of the factors used in determining *your* premium rates. *We* have the right to change premiums.

At least 45 days advance written notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *policy* or a change in a *covered person's* health. While this *policy* is in force, *we* will not restrict coverage already in force.

This policy or certificate contains a deductible provision.

As a cost containment feature, this *policy* contains prior authorization requirements. 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 POLICY

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

Celtic Insurance Company

A handwritten signature in black ink, appearing to read 'Anand Shukla', with several loops and a long horizontal stroke at the bottom.

Anand Shukla
SVP, Individual Health – Celtic Insurance Company

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DEFINITIONS

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

Acute rehabilitation is rehabilitation for patients who will benefit from an intensive, multidisciplinary rehabilitation program. Patients normally receive a combination of therapies such as physical, occupational and speech therapy as needed and are medically managed by specially trained *physicians*. Rehabilitation services must be performed for three or more hours per day, five to seven days per week, while the *member* is confined as an inpatient in a *hospital*, rehabilitation facility, or extended care facility. Please refer to the *Schedule of Benefits* for the applicable in-patient and out-patient rehabilitation limits.

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.

Allowed Amount (also Eligible Service Expense) is the maximum amount *we* will pay a provider for a covered service. When a covered service is received from a network provider, the allowed amount is the amount the provider agreed to accept from *us* as payment for that particular service. In all cases, the allowed amount will be subject to *cost sharing* (e.g., *deductible, coinsurance* and copayment) per the member's benefits.

Please note, if you receive services from a non-network provider, you may be responsible for the difference between the amount the provider charges for the service (billed amount) and the allowed amount that *we* pay. This is known as balance billing – see balance billing and non-network provider definitions for additional information.

Appeal: A grievance that is related to a denial of services or a claim in whole or part, is called an Appeal. An Appeal deals specifically with denial of the medical necessity for a service or treatment that is a benefit or for the denial of a claim for services.

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 an enrollee by the enrollee’s PCP or provider group.

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

- A person to whom a covered individual has given express, written consent to represent that individual in an internal 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*. *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.

Billed Amount is the amount a provider charges for a service

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

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 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*.

Child Health Supervision Services means *physician*-delivered or *physician*-supervised services that include the services described in the Major Medical Expense Benefits section of this *contract*. These services do not include *hospital* charges.

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. *Coinsurance* amounts are listed in the *Schedule of Benefits*. Not all *covered services* have *coinsurance*.

Complaint: A complaint is when a *member* is unhappy with Ambetter from Sunshine Health or a provider. Examples of complaints are when a *member* is unhappy with:

- Care received from a provider
- Service received from a provider
- How long it takes to get an appointment
- How *member* was treated
- Service that is not included as an Ambetter from Sunshine Health benefit
- How a bill was paid
- How they were treated by Ambetter from Sunshine Health staff.

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; and
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 *Schedule of Benefits* 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 is payable by *us*.

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*.

Covered person means *you, your* lawful *spouse* and each *eligible child*:

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

Custodial Care is treatment designed to assist a *covered person* 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.

Such treatment is custodial regardless of who orders, prescribes or provides the treatment.

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

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).

Dependent member means *your* lawful *spouse* or an *eligible child*.

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 *your* or *your spouse's* child, if that child is less than 26 years of age. As used in this definition, "child" means:

1. A natural child;
2. A newborn child from the moment of birth;
3. A legally adopted child;
4. A foster child or other child in court-ordered temporary custody;
5. A child placed with *you* for adoption; or
6. A child for whom legal guardianship has been awarded to *you* or *your spouse*. It is *your* responsibility to notify *us* if *your* child ceases to be an *eligible child*. *You* must reimburse *us* for any benefits that *we* pay for a child at a time when the child did not qualify as an *eligible child*.
7. A child from the first of the month following the month in which the child turns age twenty-six (26) until the end of the calendar year in which the child turns thirty (30) years of age; and who is a resident of Florida or a full-time or part-time student; and is not provided coverage as a named member under any other group or individual health benefit plan; or is not entitled to benefits under Title XVIII of the Social Security Act.

If a dependent child is provided coverage under the *contract* after the child reaches age twenty-six (26) and the coverage for the child is subsequently terminated prior to the end of the calendar year in which the child turns age thirty (30), the child is ineligible to be covered again under the *contract* unless the child was continuously covered by other creditable coverage without a coverage gap of more than sixty-three (63) days.

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*: When a covered service is received from a non-network provider, the eligible service expense is the minimum amount required by applicable federal or state law to be paid to the non-network provider for the service. If and only if there is no minimum amount required by applicable federal or state law, then the eligible service expense for a non-network provider shall be as determined as follows:
 - a. When a covered service is received from a non-network provider as a result of an emergency, the eligible service expense shall be the lesser of: (1) the provider's billed charges, (2) the *usual and customary* provider charges for similar services in the community where the services were provided, or (3) the charge mutually agreed to by us and the provider within 60 days of the submittal of the claim.
 - 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 non-network 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 non-network provider with us, the eligible service expense is the greater of: (1) the amount that would be paid by Medicare for the covered service, or (2) the median contracted amount paid to network

providers for the covered service in the state of Florida. You may be billed for the difference between the amount paid and the non-network provider's charge, and will also be responsible for payment of applicable copayments, *coinsurance*, and *deductible*

c. When a covered service is received from a non-network provider that is not the result of an emergency and is not approved or authorized by us, and is not within the scope of services 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 non-network provider as payment in full (you will not be billed for the difference between the negotiated fee and the non-network provider's charge). If there is no negotiated fee agreed to by the non-network provider with us, the eligible service expense will be an amount that is no less than ten percentage points lower than the percentage rate paid to network providers. This reimbursement rate will be applied to the *usual and customary* charge in the area. You may be billed for the difference between the amount paid and the non-network provider's charge and will also be responsible for payment of applicable copayments, *coinsurance*, and *deductible*.

In all cases covered by 2(a) above, *your* responsibility for payment of applicable *copayments*, *coinsurance*, and *deductible* is the same as *your* responsibility would have been had the covered emergency service been provided by a *network provider*.

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 and such 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 *covered person* 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.

With Respect to a pregnancy:

1. that there is inadequate time to effect a safe transfer to another *hospital* prior to delivery;
2. that the transfer may pose a threat to the health and safety of the patient or fetus; or
3. that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Emergency services and care shall mean medical screening, examination, and evaluation by a *physician*, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a *physician*, to determine if any emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a *physician* necessary to relieve or eliminate the emergency medical condition, within the service capability of a *hospital*.

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 48 hours 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-participating 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*.

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

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

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

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

1. Is licensed as a *hospital, extended care facility, skilled nursing facility or rehabilitation facility* by the state in which it operates;
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *physician* and the direct supervision of a registered nurse;

3. Maintains a daily record on each patient;
4. Has an effective utilization review plan;
5. Provides each patient with a planned program of observation prescribed by a *physician*; and
6. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing standards of medical practice for that condition.

Extended care facility does not include a facility primarily for rest, the aged, treatment of *substance 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 that are based on *physician* specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered expense* under the *policy*. The decision to apply *physician* specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

Grievance: A grievance is a formal written complaint submitted by an Ambetter from Sunshine Health member related to:

- Availability, coverage of, or quality of health care services including an adverse benefit determination made during the Ambetter from Sunshine Health utilization management review process;
- Claims payment to providers or Ambetter from Sunshine Health decision to not pay for health care services; or
- Concerns related to the Ambetter from Sunshine Health contract (explanation of coverage).

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 *covered person*.

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

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

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

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

Hospice refers to services designed for and provided to *members* who are not expected to live for more than 6 months, as certified by an Ambetter *physician*. Ambetter works with certified Hospice programs licensed by the state to minimize patient discomfort and address the special physical, psychological, and social needs of terminally ill members and their 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, or a patient is moved to short term observation status, a *covered person* will be deemed not to be confined in a *hospital* for purposes of this *policy*.

Illness means a sickness, disease, or disorder of a *covered person*. 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*, eligible child, or siblings of any *covered person*, or any person residing with a *covered person*.

Injury means accidental bodily damage sustained by a *covered person* 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*, which 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 *policy*. A *loss* must occur while the *covered person* is insured under this *policy*.

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 a plan no longer offers any benefits to the class of similarly situated individuals as described in 26 CFR § 54.9802-1(d) that includes the individual;
5. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent, and
6. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

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

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

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

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

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

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

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 means the *physicians*, physician's assistants, nurses, nurse clinicians, nurse practitioners, pharmacists, marriage and family therapists, clinical social workers, mental health counselors, speech-language pathologists, audiologists, occupational therapists, respiratory therapists, physical therapists, ambulance services, *hospitals*, skilled nursing facilities, or other health care providers properly licensed in the State of Florida.

Medically necessary or **medical necessity** means any medical service, supply or treatment authorized by a *physician* to diagnose and treat a *covered person'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. Demonstrates that the *member* is reasonably capable of improving in his/her functional ability;
5. Is not solely for the convenience of the *provider* or the *member*;
6. Is not *experimental or investigational*;
7. Is provided in the most cost effective care facility or setting;
8. 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
9. 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 or in a lower level or alternative setting of care.

Charges incurred for treatment not *medically necessary* are not *eligible 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 opt-out practitioner means a *medical practitioner* who:

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

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

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

Mental disorder means a behavioral, emotional, or cognitive pattern of functioning that is listed in the most recent editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or 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 *physicians* and providers who have contracts that include an agreed upon price for health care expenses.

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

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

Non-elective caesarean section means:

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

Non-network provider means a *physician* or provider who is NOT identified in the most current 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 *policy*.

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

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, workers compensation policy, 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 *covered person* 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.

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

Physician means a licensed *medical practitioner* who is practicing within the scope of his or her licensed authority in treating a bodily *injury* or sickness and is required to be covered by state law including dentists, optometrists, ophthalmologists, osteopaths, podiatrists, and chiropractors. 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.

Plan means this *policy* or *contract*. Throughout this *contract* you will see references to Celtic Insurance Company and Ambetter from Sunshine Health. Ambetter from Sunshine Health operates under its legal entity, Celtic Insurance Company, and both may be referred to as the "plan."

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

Post-service claim means any claim for benefits for medical care or treatment that has already been provided

Pre-service claim means any claim for benefits for medical care or treatment that has not yet been provided and requires the approval of the plan in advance of the *member* obtaining the medical care.

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

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

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

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

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

Prosthetic device means a medically necessary device used to replace, correct, or support a missing portion of the body, to prevent or correct a physical deformity or malfunction, or to support a weak or deformed portion of the body.

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

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

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

1. Is licensed by the state as a *rehabilitation facility*; and
2. Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

Rehabilitation facility does not include a facility primarily for rest, the aged, long term care, assisted living, *custodial care*, 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 *covered person* in order to provide relief to the *covered person's immediate family* or other caregiver.

Skilled Nursing Facility means services that include *physician* services, room and board limited to semi-private rooms, unless a private room is *medically necessary* or a semi-private room is not available, and patient meals, general nursing care, rehabilitative services, drugs (drugs and biologicals), medical supplies and the use of appliances and equipment furnished by skilled nursing facility. Limitations apply, see *your Schedule of Benefits*.

Social determinants of health are the circumstances in which people are born, grow up, live, work, and age. This also includes the systems in place to offer health care and services to a community.

Specialist is a *physician* or *medical practitioner* who focuses on a specific area of medicine and has additional expertise to help treat specific disorders or illnesses. *Specialists* may be needed to diagnose, manage, or treat certain types of symptoms and conditions related to their specific field of expertise.

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 abuse disorders* are those listed in the most recent editions of the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases,

Surgery or **surgical procedure** means:

1. An invasive diagnostic procedure; or
2. The treatment of a *covered person's illness* or *injury* by manual or instrumental operations, performed by a *physician* while the *covered person* 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.

Surrogate means a gestational carrier who, as part of a *Surrogacy Arrangement*, (a) uses her own egg that is fertilized by a donor or (b) has a fertilized egg placed in her body but the egg is not her own.

Surrogacy Arrangement means an understanding in which a woman (the *surrogate*) agrees to become pregnant and carry a child (or children) for another person (or persons) who intend to raise the child (or children), whether or not the *surrogate* receives payment for acting as a *surrogate*.

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

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

Terminally ill means a *physician* has given a prognosis that a *covered person* 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 *covered person* for payment of any of the *covered person'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 *covered person* is entitled to benefits as a named insured person or an insured *dependent* 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 *policy* was completed by the *covered person*, including all tobacco products but excluding religious and ceremonial uses of tobacco.

Transcranial Magnetic Stimulation (TMS): TMS is a non-invasive procedure in which a changing magnetic field is used to cause electric current to flow in a small targeted region of the brain via electromagnetic induction.

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; and
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 *covered person's* health; and
2. As a result of an unforeseen *illness, injury*, or the onset of acute or severe symptoms.

Usual and customary means the fair market value of the service provided (i.e. what a willing buyer will pay and a willing seller will accept in an arm's-length transaction). In determining the fair market value of the service provided, we consider, among other things, the amounts reasonably accepted by providers, when available, for the service or similar services in the geographical area in which the service was received.

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, *case management*, discharge planning, or retrospective review.

DEPENDENT COVERAGE

Dependent Member Eligibility

Your *dependent members* become eligible for coverage under this *policy* on the latter of:

1. The date *you* became covered under this *policy*; or
2. The date of marriage to add a spouse; or
3. The date of an eligible newborn's 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 *dependents* will be the same date as your initial coverage date. Only *dependents* included in the application for this *policy* will be covered on your *effective date*.

Coverage for a Newborn Child

An eligible child born to *you* or your covered family member(s) will be covered from the time of birth until the 31st day after its birth. Each type of covered service incurred by the newborn child will be subject to the *cost sharing* amount listed in the *Schedule of Benefits*.

The coverage, benefits or services for newborns shall consist of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or pre-maturity and up to \$1,000 transportation costs of the newborn to and from the nearest appropriate facility staffed and equipped to treat the newborn's condition when such transportation is certified by the treating provider as necessary to protect the health and safety of the newborn child.

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* 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 within the 31 days from birth, *we* will charge an additional premium from the date of birth. If notice is given to *us* within 60 days of the birth of the child, the *policy* 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 for an Adopted Child

Coverage for children under this *policy* will be provided for the adopted child of a *member* who has family coverage. Coverage is provided from the moment of placement to a child the *member* proposes to adopt who is placed in the *member's* residence in compliance with Chapter 63, Florida Statutes. A newborn infant who is adopted by the *member* is covered from the moment of birth if a written agreement to adopt such child has been entered into prior to the birth of the child, whether or not such agreement is enforceable. However, coverage will not be provided in the event the child is not ultimately placed in the *member's* residence in compliance with chapter 63, Florida Statutes.

The *member's* adopted child is covered from the moment of placement in the residence, or if a newborn, from the moment of birth, if the child is enrolled timely as specified in the Special and Limited Enrollment Period provision.

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child. 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) written notice of *your* or *your spouse's* intent to adopt the child; 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* apply in writing for insurance on a *dependent* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent* is insured.

ONGOING ELIGIBILITY

For All Covered Persons

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

1. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *contract* or the date that *we* have not received timely premium payments in accordance with the terms of this *contract*; or
2. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact (e.g., the date that a *member* accepts any direct or indirect contributions or reimbursement by or on behalf of an employer, for any portion of the premium for coverage under this *contract*); or
3. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes; or
4. The date *we* decline to renew this *contract*, as stated in the Discontinuance provision; or
5. The date of a *member's* death; or
6. The date a *member's* eligibility for coverage under this *contract* ceases due to losing network access as the result of a permanent move.

For Dependent Members

A *dependent* will cease to be a *covered person* at the end of the premium period in which he or she ceases to be *your dependent* due to divorce or if a child ceases to be an *eligible child*. For eligible children, coverage will terminate the thirty-first of December the year that the dependent turns 30 years of age.

We must receive notification within 90 days of the date an insured ceases to be an eligible *dependent*. If notice is received by *us* more than 90 days from this date, any unearned premium will be credited only from the first day of the calendar month in which *we* receive the notice.

A *covered person* 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.

If health benefits are denied for the stated reason that the child has reached the limiting age for dependent coverage specified in this *contract*, the *member* has the burden of establishing that the child continues to meet the criteria specified above. Failure to provide the required proof may result in the dependent's termination of coverage.

The coverage of the handicapped child may be continued, but not beyond the termination date of such incapacity or such dependence. This provision shall in no event limit the application of any other *contract* provisions terminating such child's coverage for any other reason than the attainment of the limiting age.

Open Enrollment

There will be an open enrollment period for coverage. The open enrollment period begins November 1, 2019 and extends through December 15, 2019. Individuals who enroll on or before December 15, 2019 will have an *effective date* of coverage on January 1, 2020.

Special and Limited Enrollment

An *individual* has 60 days to enroll as a result of one of the following events:

1. An *individual* or *dependent* loses *minimum essential coverage*;
2. An *individual* gains a dependent or becomes a *dependent* or *eligible child*;

3. An individual who was not previously a citizen, national, or lawfully present individual gains such status;
4. An individual's enrollment or non-enrollment in a health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an agent;
5. An *individual* or enrollee gains access to new health plans as a result of a permanent move;
6. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended; or

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.

PREMIUMS

Premium Payment

Each premium is to be paid on or before its due date. A due date is the last day of the period for which the preceding premium was paid.

Grace Period

After the first premium is paid, a grace period of 31 days from the premium due date is given for the payment of premium. 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, coverage will remain in force.

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

Misstatement of Tobacco Use

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

Billing/Administrative Fees

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

COST SHARING FEATURES

Cost Sharing Features

We will pay benefits for *covered services* as described in the Schedule of Benefits and the Major Medical Expense Benefits section 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* is listed in *your Schedule of Benefits*.

When *you*, or a covered dependent, receive health care services from a provider, there may be multiple claims for that episode of care. An episode of care means the services provided by a health care facility or provider to treat a condition or an illness. Each claim that *we* receive for services covered under this contract are adjudicated or processed as *we* receive them. Coverage is only provided for eligible service expenses. Each claim received will be processed separately according to the cost share as outlined in the contract and in *your Schedule of Benefits*.

Copayments

A copayment is typically a fixed amount due at the time of service. *Members* may be required to pay copayments to a provider each time services are performed that require a copayment. Copayments are due as shown in the *Schedule of Benefits*. Payment of a copayment does not exclude the possibility of a provider billing *you* for any non-covered services. Copayments do not count or apply toward the *deductible* amount, but do apply toward *your maximum out-of-pocket* amount.

Coinsurance Amount

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

Deductible

The *deductible amount* means the amount of *covered service expenses* that must be paid by each/all *members* before any benefits are provided or payable. The *deductible amount* 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. *Deductible amounts* are applied for a calendar year and do not roll over to the next calendar year.

Maximum Out-of-pocket

You must pay any required copayments or *coinsurance* amounts required until *you* reach the *maximum out-of-pocket* amount shown on *your Schedule of Benefits*. After the *maximum out-of-pocket* amount is met for an individual, *we* will pay 100% of the cost for covered services. The family *maximum out-of-pocket* Amount is two times the individual *Maximum Out-of-Pocket* Amount. For the family *Maximum Out-of-Pocket* amount, once a *member* has met the individual *maximum out-of-pocket* amount, the remainder of the family *maximum out-of-pocket* amount can be met with the combination of any one or more *members'* eligible service expenses.

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*.

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 *contract* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

Coverage under Other 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*.

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 *maximum out-of-pocket*.

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 services* 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 expenses will include ambulance services for local transportation:

1. To the nearest *hospital* that can provide services appropriate to the *covered person'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 Sunshine Health.

Benefits for air ambulance services are limited to:

1. Services requested by police or medical authorities at the site of an *emergency*; or
2. Those situations in which the *covered person* 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; or
4. Ambulance services provided for a *covered person's* comfort or convenience.
5. Non-emergency transportation excluding ambulances (for example transport van, taxi).

Mental Health and Substance Abuse Expense Benefits

The coverage described below is intended to comply with requirements under the Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Mental health services will be provided on an inpatient and outpatient basis and include treatable mental health conditions. These conditions affect the individual's ability to cope with the requirements of daily living. If *you* need mental health and/or substance use disorder treatment, *you* may choose any provider participating in *our* behavioral health network. *Deductible* amounts, copayment or *coinsurance* amounts and treatment limits for covered mental health and substance use disorder benefits will be applied in the same manner as physical health service benefits.

Covered services for mental health and substance use disorder are included on a non-discriminatory basis for all members for the diagnosis and medically necessary and active treatment of mental, emotional, or substance use disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association or the International Statistical Classification of Diseases and Related Health Problems (ICD).

When making coverage determinations, *our* utilization management staff employ established level of care guidelines and medical necessity criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. They utilize McKesson's Interqual criteria for mental health determinations and American Society of Addiction Medicine (ASAM) criteria for substance abuse determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not medically necessary will be made by a qualified licensed mental health professional.

Covered *inpatient* and *outpatient* mental health 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. Individual and group therapy for mental health and *substance use*;
2. Medication management services;
3. Outpatient detoxification programs;
4. Psychological and neuropsychological testing and assessment;
5. Applied Behavioral Analysis for treatment of autism;
6. *Telehealth*;
7. Partial Hospitalization Program (PHP);
8. Medication assisted treatment – combines behavioral therapy and medications to treat *substance use* disorders;
9. Intensive Outpatient Program (IOP);
10. Evaluation and assessment for mental health and substance use;
11. Mental Health day treatment ;
12. Electroconvulsive Therapy (ECT).
13. *Transcranial Magnetic Stimulation (TMS)*.

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; or
- habilitation services, limited to children ages 0 to 21 with a diagnosis of *autism spectrum disorder*; or
- medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

Covered expenses include expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:

1. *Covered expenses* available to a *covered person* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision;
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay;
3. *Covered expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
 - a. Daily room and board and nursing services;
 - b. Diagnostic testing; and
 - c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration;
4. *Covered expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners*.
5. Outpatient physical therapy, occupational therapy, respiratory, pulmonary or inhalation therapy and speech therapy.

Custodial care services are not covered under this policy. 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 *covered person* has reached *maximum therapeutic benefit*;
2. Further treatment cannot restore bodily function beyond the level the *covered person* already possesses;
3. There is no meaningful measurable progress toward documented goals; and
4. Care is primarily *custodial care*.

Home Health Care Expense Benefits

1. *Covered Services and supplies* for *Home Healthcare* are covered when *your physician* indicates you are not able to travel for appointments to a medical office. Coverage is provided for *medically necessary in-network* care provided at the *member's* home and includes the following: *home health*

aide services, only if provided in conjunction with skilled registered nurse or licensed practical nursing services;

1. Skilled services of a registered nurse or licensed practical nurse rendered on an outpatient basis;
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care*;
3. I.V. medication and pain medication;
4. Hemodialysis, and for the processing and administration of blood or blood components;
5. *Necessary medical supplies*; and
6. Rental or purchase of *medically necessary durable medical equipment*.
7. Sleep Studies.

I.V. medication and pain medication are *covered expenses* to the extent they would have been *covered 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. *Home health care* services not in conjunction with a registered or licensed practical nurse and *home health aide* are not covered

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 Expense Benefits

Hospice care benefits are allowable for a *terminally ill covered person* receiving *medically necessary* care under a *hospice care program*. *Covered services* include:

1. Room and board in a *hospice* while the *covered person* 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 *policy* if the *covered person* 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 *covered person* regarding his or her *terminal illness*;
7. *Terminal illness counseling* of members of the *covered person's immediate family*; and
8. *Bereavement counseling*.

Benefits for *hospice inpatient*, home and outpatient care are available for one continuous period up to 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 *inpatient* or outpatient basis to allow temporary relief to family members from the duties of caring for a *covered person* under hospice care. Respite days that are applied toward the *deductible amount* are considered benefits provided and shall apply against any maximum benefit limit for these services.

Medical Foods

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

Excluded are any other dietary formulas, oral nutritional supplements, special diets, prepared foods or meals, baby formula or food and formula for access problems.

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* feel 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 Ambetter from Sunshine Health 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*. The plan may allow a second opinion from a *non-network* provider which will be subject to *prior authorization* and *medical necessity* review.

Hospital Benefits

Covered service expenses are limited to 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.

Medical Expense Benefits

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 hemodialysis, and the charges by a *hospital* or dialysis center for processing and administration of blood or blood components.
9. For the cost and administration of an anesthetic.
10. For dental treatment in a *hospital* or ambulatory surgical center. Benefits are available for general anesthesia and hospitalization services in connection with necessary dental treatment or surgery, subject to *prior authorization* by us.
 1. A *member* under age eight (8) whose treating health care professional, in consultation with the dentist, determines the child has a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or
 2. A *member* who has one (1) or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any dental treatment or surgery if not rendered in a *hospital* or ambulatory surgical center.

Necessary dental treatment is that which, if left untreated, is likely to result in a medical condition. Use of general anesthesia in a *hospital* or ambulatory surgical center is subject to *prior authorization* by us. Please call Member Services to confirm *your* benefits for the use of general anesthesia in a *hospital* or ambulatory surgical center.

11. For oxygen and its administration.
12. 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 sound 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 sound natural teeth will not include any injury as a result of chewing.
13. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint. See the *Schedule of Benefits* for benefit levels or additional limits.
14. For reconstructive breast surgery charges as a result of a partial or total mastectomy. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas. Coverage for outpatient post-surgical care is provided in the most medically appropriate setting which may include a *hospital*, treating *physician's* office, outpatient center or the *member's* home. *Inpatient hospital* treatment for mastectomy will not be limited to any period that is less than that recommended by the attending *physician*.
15. 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 *deductible amount* and *cost sharing percentage* provisions.
16. *Covered service expenses* are permitted when a *member* receives services from a *network provider* specializing in obstetrics and gynecology for obstetrical or gynecological care or if *medically necessary* follow-up care is detected at the visit without a referral.
17. 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; and
 - e. Implantable prosthetic lenses, in connection with cataracts.
18. Family Planning for certain professional provider contraceptive services and supplies, including but not limited to sterilization and vasectomies, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.

19. *Covered services* for *medically necessary* diagnosis and treatment of osteoporosis for high-risk *member*, including, but not limited to, estrogen-deficient *members* who are at clinical risk for osteoporosis, *members* who have vertebral abnormalities, individuals who are receiving long-term hyperparathyroidism and *members* who have a family history of osteoporosis.
20. Cleft lip and cleft palate for an *eligible child* under the age of 18. *Covered services* includes medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the treating *physician* or surgeon and such *physician* or surgeon certifies that such services are *medically necessary* and consequent to treatment of the cleft lip or cleft palate.
21. For Dermatology services which are limited to the following: *Medically necessary* minor surgery, tests, and office visits provided by a dermatologist who is a *network provider*.
22. Mammograms as follows: (a) A baseline mammogram for any *covered person* who is 35 to 40 years of age; (b) A mammogram every 2 years for any *covered person* who is 40 to 50 years of age or older, or more frequently based on the patient's *physician's* recommendations; (c) A mammogram every year for any *covered person* who is 50 years of age or older; (d) One or more mammograms a year, based upon a *physician's* recommendation for any *covered person* who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has had breast cancer, or because a *covered person* has not given birth before the age of 30. This benefit is not subject to *deductibles* or *copayments*.
23. For *medically necessary* genetic blood tests.
24. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
25. For *medically necessary* allergy treatment including allergy injection.

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.

Dialysis Services

Medically necessary acute and chronic dialysis services are covered benefits unless other coverage is primary, such as Medicare for dialysis. There are two types of treatment provided *you* meet all the criteria for treatment. *You* may receive hemodialysis in an *in-network* dialysis Facility or peritoneal dialysis in *your* home from a *network provider* when *you* qualify for home dialysis.

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 supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs but not the replacement thereof, unless required by a physical change in the *covered person* and the item cannot be modified. If more than one prosthetic device can meet a *covered person's* functional needs, only the charge for the most cost effective prosthetic device will be considered a *covered expense*;
2. For one pair of foot orthotics per year per *covered person*;
3. For the purchase or rental of a medically necessary durable medical equipment;
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 a habilitation equipment specialist or vendor should be done to estimate the cost of repair.
3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4. The equipment, supply or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include the following:

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

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

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).

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. Wigs (except as described above following cancer treatment).
5. Penile prosthesis in member's experiencing impotency resulting from disease or injury or for cosmetic purposes.

Orthotic devices

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

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

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

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

Exclusions:

Non-covered services include but are not limited to:

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

Prescription Drug Expense Benefits

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

1. A *prescription drug*; and
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician*.

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

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

Non-Formulary Prescription Drugs:

Under Affordable Care Act, *you* have the right to request coverage of prescription drugs that are not listed on the plan formulary (otherwise known as "non-formulary drugs"). To exercise this right, please get in touch with *your medical practitioner*. *Your medical practitioner* can utilize the Prescription Drug Exception request process.

Prescription Drug Exception Process

1. Standard exception request

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

2. Expedited exception request

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

3. External exception request review

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

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

Non-Covered Services and Exclusions:

No benefits will be paid under this benefit subsection for services provided or expenses incurred:

1. For *prescription drug* treatment of erectile dysfunction or any enhancement of sexual performance unless such treatment is listed on the formulary.
2. For weight loss prescription drugs unless otherwise listed on the formulary.
3. For immunization agents, blood, or blood plasma, except when used for preventative care and listed on the formulary.
4. For medication that is to be taken by the *member*, in whole or in part, at the place where it is dispensed.
5. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
6. For a refill dispensed more than 12 months from the date of a *physician's* order.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. 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 on the formulary.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For any drug that *we* identify as therapeutic duplication through the Drug Utilization Review program.
11. For more than a 30-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. Specialty drugs are limited to 30-day supply when dispensed by retail or mail order.
12. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
13. 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 document if obtained in the United States.

14. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventative treatment is related to *member's* vacation during out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
15. For medications used for cosmetic purposes.
16. For infertility drugs unless otherwise listed on the formulary.
17. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
18. For 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 such drugs or dosage amounts have been approved by any governmental regulatory body for that use.
19. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
20. For any drug dispensed from a non-lock-in pharmacy while *member* is in opioid lock-in program.
21. For any drug related to *surrogate* pregnancy.
22. For any drug used to treat hyperhidrosis.

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.

Lock-in Program

To help decrease opioid overutilization and abuse, certain members identified through *our* Lock-in Program, may be locked into a specific pharmacy for the duration of their participation in the lock-in program. Members locked into a specific pharmacy will be able to obtain their medication(s) only at specified location. Ambetter pharmacy, together with Medical Management will review *member* profiles and using specific criteria, will recommend members for participation in lock-in program. Members identified for participation in lock-in program and associated providers will be notified of *member* participation in the program via mail. Such communication will include information on duration of participation, pharmacy to which *member* is locked-in, and any appeals rights.

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 for any brand name drug that is available as a generic version. If there is no generic version of the drug available, or if you have completed the appeal process or drug exception process and it has been determined that the brand name drug is the appropriate option, then any *cost sharing* paid on your behalf will count toward *your deductible* and *your* maximum out of pocket.

Pediatric Vision Benefits – Children under the age of 19

Coverage for vision services is provided for children, under the age of 19, from a *network provider* through the end of the plan year in which they turn 19 years of age.

1. Routine ophthalmological exam
 - a. Refraction;
 - b. Dilation;
 - c. Contact lens fitting.
2. Frames
3. Prescription lenses
 - a. Single;
 - b. Bifocal;
 - c. Trifocal;
 - d. Lenticular; or
 - e. Contact lenses (in lieu of glasses).
4. Additional lens options (including coating and tints)
 - a. Progressive lenses (standard or premium);
 - b. Intermediate vision lenses;
 - c. Blended segment lenses;
 - d. Hi-Index lenses;
 - e. Plastic photosensitive lenses;
 - f. Photochromic glass lenses;
 - g. Glass-grey #3 prescription sunglass lenses;
 - h. Fashion and gradient tinting;
 - i. Ultraviolet protective coating;
 - j. Polarized lenses;
 - k. Scratch resistant coating;
 - l. Anti-reflective coating (standard, premium or ultra);
 - m. Oversized lenses;
 - n. Polycarbonate lenses.
5. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

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

Services not covered:

1. Visual therapy;
2. Two pair of glasses as a substitute for bifocals;
3. Non-network care without *prior authorization*.

Medically Necessary Vision Services

Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by a participating *network 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 material not specifically listed as a covered service;
- Low vision services and hardware for adults; and

- Non- *network* care, except when *prior -authorized*

Preventive Care Expense Benefits

Covered expenses are expanded to include the charges incurred by a *covered person* for the following preventive health services if appropriate for that *covered person* 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;
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 which includes well-child care from birth;
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration;
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 per calendar year 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*, and *coinsurance* provisions under the *policy* 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.

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

As new recommendations and guidelines are issued, those services will be considered *covered 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.

Child Health Supervision Services

The following *covered service* is provided for an *eligible child* in accordance with the Florida Child Health

Assurance Act which includes *covered services* from the moment of birth to age 16 years. A waiver of the *deductible amount* applies to all eligible expenses for Child Health Supervision Services.

Child Health Supervision Services means *physician-delivered* or *physician-supervised* services. These services do not include *hospital* charges.

Child Health Supervision Services include periodic visits, which shall include:

- History
- Physical Examination
- Developmental Assessment
- Anticipatory Guidance
- Appropriate Immunizations
- Laboratory Testing

These services and periodic visits will be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

Eligible service expenses for Child Health Supervision Services are limited to one visit payable to one provider for all the services provided at each visit.

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.

Note: This provision does not amend the contract to restrict any terms, limits, or conditions that may otherwise apply to *surrogates* and children born from *surrogates*. Please see General Non-Covered Services and Exclusions.

Duty to Cooperate. Members who are a *surrogate* at the time of enrollment or Members who agree to a *Surrogacy Arrangement* during the plan year must, within 30 days of enrollment or agreement to participate in a *Surrogacy Arrangement*, send us written notice of the *Surrogacy Arrangement* in accordance with the notice requirements set forth in General Provisions herein. In the event that a *member* fails to comply with this provision, we reserve *our* right to enforce this EOC on the bases of fraud, misrepresentation or false information, up to and including recoupment of all benefits that we paid on behalf of the *surrogate* during the time that the *surrogate* was insured under *our* policy, plus interest, attorneys' fees, costs and all other remedies available to us.

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 insureds who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

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

- 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, non-investigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational 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.

Social Determinants of Health Supplemental Benefits

Social determinants of health supplemental benefits and services may be offered to enrollees to remove barriers to accessing health services and improve overall health outcomes. These are benefits and services that we may make available in connection with this contract. The benefits and services provided may include transportation to health services, assistance with childcare, access to healthy meals, and other relevant services based on need. The benefits are available as long as coverage remains active, unless changed by us. Upon termination of coverage, the benefits are no longer available. All enrollees are automatically eligible for the benefits upon obtaining coverage. The services are optional, and the benefits are made available at no additional cost to the enrollees. The benefits and services available at any given time are made part of this contract by this reference and are subject to change by us through an update to information available on *our* website or by contacting us. Social determinants of health benefits and services may be offered to enrollees through the "My Health Pays" wellness program and through local health plan websites. Enrollees may receive notifications about available benefits and services through emails from local health plans and through the "My Health Pays" notification system. To inquire about these benefits and services or other benefits available, *you* may visit *our* website at Ambetter.SunshineHealth.com or by contacting Member Services at 877-687-1196 (Relay FL 1-800-955-8770).

Transplant Service Expense Benefits

Transplants are a covered benefit when a *member* is accepted as a transplant candidate and pre-authorized in accordance with this *contract*. Transplant services must be provided by an *in-network provider* and facility, and meet other medical criteria as set by medical management policy and the medical providers performing the transplant.

Covered Services and Supplies for transplant service expenses:

1. Pre-transplant evaluation;
2. Pre-transplant harvesting;
3. Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *covered person* 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* and
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 *covered person* if:

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

Ancillary "Center Of Excellence" Benefits:

A *covered person* 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 expenses* for the *medically necessary transplant* will include the acquisition cost of the organ or bone marrow; and
2. We will pay a maximum of \$10,000 per lifetime for the following services:
 - a. Transportation for the *covered person*, any live donor, and the *immediate family* to accompany the *covered person* 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 *covered person* while the *covered person* is confined in the *Center of Excellence*. We will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Exclusions:

No benefits will be paid under these Transplant Expense Benefits for charges:

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 procurement or transportation of the organ or tissue, unless expressly provided for in this provision;
5. To keep a donor alive for the transplant operation;
6. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ;
7. Related to transplants not included under this provision as a *medically necessary transplant*; and
8. 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 (*USFDA*) regulation, regardless of whether the trial is subject to *USFDA* oversight. Note: This exclusion does not apply to bone marrow transplants.

Limitations on Transplant Expenses Benefits:

In addition to the exclusions and limitations specified elsewhere in this section:

1. Bone marrow transplant coverage for the reasonable costs of searching for a donor will be limited to a search among family members and donors identified through the National Bone Marrow Donor Program.
2. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Urgent Care Services

Urgent Care services include *medically necessary* services by *in-network providers* and services provided at an *Urgent Care Center* including facility costs and supplies. Care that is needed after a *primary care provider's* normal business hours is also considered to be Urgent Care. *Your zero cost sharing* Preventive Care Benefits may not be used at an Urgent Care Center.

Members are encouraged to contact their *primary care provider* for an appointment before seeking care from another provider, but *network urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *primary care provider* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-877-687-1197. The 24/7 Nurse Advice Line is available twenty-four (24) hours a day, seven (7) days a week. A registered nurse can help *you* decide the kind of care most appropriate for *your* specific need.

PRIOR AUTHORIZATION

Prior Authorization Required

Some *covered expenses* require *prior authorization*. *Network providers* must obtain *authorization* from us prior to providing a service or supply to a *covered person*. However, there are some *network eligible 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. Receives 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, efax or provider portal as follows:

1. At least 5 days prior to an elective admission as an *inpatient* in a *hospital*, extended care or rehabilitation facility, or hospice facility.
2. At least 30 days prior to the initial evaluation for organ transplant services.
3. At least 30 days prior to receiving clinical trial services.
4. 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 *covered person*.

Failure to Obtain Prior Authorization

Failure to comply with the *prior authorization* requirements will result in benefits being reduced.

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, we do not normally cover services received from *non-network providers*. If a situation arises where a covered service cannot be obtained from a *network provider* located within a reasonable distance, we may provide a *prior authorization* for you to obtain the service from a *non-network provider* at no greater cost to you than if you went to a *network provider*. If covered services are not available from a *network provider*, you or your *primary care provider* must request *prior authorization* from us before you receive services from a *non-network provider*. Otherwise, you will be responsible for all charges incurred.

Florida law requires that we provide you with the following disclosure about your health benefit plan coverage. "WARNING: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered nonemergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to your policy's out-of-network reimbursement benefit. Nonparticipating providers may bill insureds for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT.

Participating providers have agreed to accept discounted payments for services with no additional billing to you other than coinsurance, copayment, and deductible amounts. You may obtain further information about the providers who have contracted with your insurance plan by consulting your insurer's website or contacting your insurer or agent directly."

Hospital Based Providers

When receiving care at an Ambetter participating *hospital* it is possible that some *hospital*-based providers (for example, anesthesiologists, radiologists, hospitalists, pathologists) may not be under contract with Ambetter as participating providers. These providers may not bill you for the difference between Ambetter's allowed amount and the providers billed charge. This practice is known as "*balance billing*". However, 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.

GENERAL LIMITATIONS AND EXCLUSIONS

No benefits will be paid for:

1. Any service or supply that would be provided without cost to *you* or *your covered dependent* in the absence of insurance covering the charge;
2. Expenses, fees, taxes or surcharges imposed on *you* or *your covered dependent* by a provider, including a *hospital*, but that are actually the responsibility of the provider to pay;
3. Any services performed for a *member* by a *covered person's immediate family*; and
4. Any services not identified and included as *covered expenses* under the *policy*. *You* will be fully responsible for payment for any services that are not *covered expenses*.
5. Court ordered care unless *medically necessary* and a *covered service expense* or is required by law.
6. Any services where other coverage is primary must be first paid by the primary payor prior to consideration for coverage under this *contract*.

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

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

Covered expenses will not include, and no benefits will be 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 *policy*, except as expressly provided for under the Benefits After Coverage Terminates clause in this *policy's* Termination section;
2. For any portion of the charges that are in excess of the *eligible expense*;
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*;
4. For cosmetic breast reduction or augmentation except post-mastectomy for breast cancer and the *medically necessary* treatment of gender dysphoria;
5. For reversal of sterilization and vasectomies;
6. For abortion unless the life of the mother would be endangered if the fetus were carried to term.
7. For expenses for television, telephone, or expenses for other persons;
8. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions;
9. For telephone consultations, except those meeting the definition of *telehealth* services, or for failure to keep a scheduled appointment;
10. For stand-by availability of a *medical practitioner* when no treatment is rendered;
11. For *dental expenses*, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under the Medical and Surgical Expense Benefits provisions;
12. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a functional defect or birth defect in a child who has been a *covered person* from its birth until the date *surgery* is performed;
13. Mental Health Services are excluded: (a) for evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless a plan provider determines such evaluation to be medically necessary; (b) when ordered by the court, to be used in a court proceeding, or as a condition of a parole or probation, unless a plan provider determines such services to be medically necessary; (c) court ordered testing and testing for ability, aptitude, intelligence or interest; (d) services which are custodial or residential in nature; (e) habilitative services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.

14. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant 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 by the *policy*;
17. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*;
18. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine;
19. For eyeglasses, contact lenses, hearing aids, including bone anchored hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the *policy*;
20. For *experimental or investigational treatment(s) or unproven services*. The fact that an *experimental or investigational treatment or unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment or unproven service* for the treatment of that particular condition;
21. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of 90 consecutive days;
22. As a result of an *injury or illness* arising out of, or in the course of, employment for wage or profit, if the *covered person* 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 *covered person'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 *covered person's* workers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency;
23. As a result of:
 - a. The *covered person* taking part in a riot; or
 - b. The *covered person's* commission of, or participation in, a felony, whether or not charged;
24. For or related to treatment of hyperhidrosis (excessive sweating);
25. For fetal reduction surgery;
26. Except as specifically identified as a *covered expense* under the *policy*, expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health;
27. 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; racing or speed testing any non-motorized vehicle or conveyance, if the *covered person* is paid to participate or to instruct; rodeo sports; horseback riding, if the *covered person* is paid to participate or to instruct; rock or mountain climbing, if the *covered person* is paid to participate or to instruct; or skiing, if the *covered person* is paid to participate or to instruct;
28. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *covered person* 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;
29. For prescription drugs for any *covered person* 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; and

30. For the following miscellaneous items: Infertility treatment including but not limited to; Artificial Insemination, Vitro, Intra-Cytoplasmic Sperm Injection(ICSI), Gamete Intrafallopian Transfer(GIFT), Zygote Intrafallopian Transfer(ZIFT) (except where required by federal or state law); biofeedback; blood and blood products, unless specifically described in this *contract*; 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; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-member biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; private duty nursing; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the *service area*; non-medically necessary sclerotherapy for varicose veins ; treatment of spider veins; transportation expenses, unless specifically described in this *contract*; incontinence supplies; expenses related to home or vehicle modification; or convenience items.
31. For *illness* or *injury* 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*.
32. For diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
33. For penile prosthetic surgery or for complications resulting from a penile implant.
34. For any claim submitted by non lock-in pharmacy while *member* is in lock-in status. To facilitate appropriate benefit use and prevent opioid overutilization, member's participation in lock-in status will be determined by review of pharmacy claims.
35. *Surrogacy Arrangement*. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a Member, and any child born as a result of a *Surrogacy Arrangement*. This exclusion applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
 - (a) Prenatal care;
 - (b) Intrapartum care (or care provided during delivery and childbirth);
 - (c) Postpartum care (or care for the *surrogate* following childbirth);
 - (d) Mental Health Services related to the *Surrogacy Arrangement*;
 - (e) Expenses relating to donor semen, including collection and preparation for implantation;
 - (f) Donor gamete or embryos or storage of same relating to a *Surrogacy Arrangement*;
 - (g) Use of frozen gamete or embryos to achieve future conception in a *Surrogacy Arrangement*;
 - (h) Preimplantation genetic diagnosis relating to a *Surrogacy Arrangement*;
 - (i) Any complications of the child or *surrogate* resulting from the pregnancy; or
 - (j) Any other health care services, supplies and medication relating to a *Surrogacy Arrangement*.

Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *Surrogacy Arrangement* are also excluded, except where the child is the adoptive child of insureds possessing an active policy with us and/ or the child possesses an active policy with us at the time of birth.

Limitation on Benefits for Services Provided By Medicare Opt-Out Practitioners

Benefits for *covered expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.

Plan Administration

In consideration of the payment of premiums we will provide coverage for the *member* and any *eligible dependents*. In doing so, we may enter into agreements with providers of health care and such other individuals and entities as may be necessary to enable us to fulfill our obligations under this *contract*.

We agree to provide coverage without discrimination because of race, color, national origin, disability, sex, gender identity, sexual orientation, religion, or any other basis prohibited by law.

Commencement of Coverage

Commencing on the *contract effective date* we agree to provide the coverage stipulated in this *contract* to the *member* and his/her *dependents*, if any. Such coverage begins on the *member's* effective date, which will be the first of the month after the receipt and approval of the application by us, unless this *contract* specifies a date other than the first of the month. We accept no liability for benefits related to expenses incurred prior to *your* effective date or after *your* termination date, which will be on the last day of the coverage month, except or as specified in the Terms of Renewal provision.

Plan Renewal

This *contract* is guaranteed renewable. Guaranteed renewable means that this *contract* will renew each year on the anniversary date unless terminated earlier in accordance with *contract* terms. You may keep this *contract* in force by timely payment of the required premiums. We may decide not to renew as of the renewal date if: (1) we decide not to renew all *contracts* issued on this form, with the same type and level of benefits, to residents of the state where you then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits. Rate changes are effective on a *member's* annual renewal date and will be based on each *member's* attained age, family structure, geographic region, tobacco usage and benefit plan at the time of renewal. We will notify the *member* in writing at least forty-five (45) days prior to the renewal date of any change in premium rates.

For *members* who have elected the electronic funds transfer option of payment, should premiums change at renewal, we will continue to draft the new monthly premium.

Term of Renewal

We guarantee the *member* the right to renew the contract each year, at the *member's* option. However, we may refuse to renew this *contract*, and all coverage provided under this *contract*, if one of the following circumstances has occurred:

1. Failure to timely pay premium in accordance with the terms of the *contract*;
2. We cease offering this contract to all *members*;
3. The *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this *contract*;
4. The *member* no longer lives in our geographic service area;
5. We elect to discontinue all individual health coverage in the State of Florida; and
6. We elect to discontinue offering individual health coverage through the Health Insurance Marketplace.

With the exception of non-payment of premium or loss of eligibility, if we decide to terminate or non-renew this contract for any of the reasons set forth in this *contract*, we will give the *member* at least forty-five (45) days advance written notice prior to renewal. If we discontinue offering all individual coverage in Florida, we will give all *members* and the Office of Insurance Regulation 180 day's written notice prior to the *contract* non-renewal date.

Termination of This Contract by the Member

The *member* may terminate this *contract* at any time with appropriate notice to *us*. Coverage will terminate on the date that *we* receive a request from *you* to terminate this *contract*, or any later date stated in *your* request. No benefits will be provided as of the effective date of termination of this *contract* for whatever reason.

Should the *member* or any covered dependents terminate coverage because of eligibility for Medicaid, Children's Health Insurance Program (CHIP) or a Basic Health Plan, the termination effective date will be the day before the effective date of the new coverage.

Discontinuance of a Benefit Plan

We may discontinue offering a particular benefit plan to all *members* if:

1. *We* provide at least one hundred and eighty(180) day notice to each *member* prior to the contract renewal date;
2. *We* offer each *member* the option to purchase any other coverage offered in the individual Health Maintenance Organization (HMO) market; and
3. *We* act uniformly without regard to any health status-related factor of each *member*.

Discontinuance of All Coverage in the Individual Market

We may discontinue offering all coverage in Florida if:

1. *We* provide notice to the Office of Insurance Regulation and each *member* and enrollee 180 days prior to renewal; and
2. All health coverage issued or delivered for issuance in Florida is discontinued and coverage under such health coverage is not renewed.

Termination of this Plan by Us

Except for nonpayment of premium or termination of eligibility, *we* may not cancel or terminate or non-renew this *contract* without giving the *member* at least forty-five (45) days written notice. The written notice will state the reason or reasons for the cancellation, termination or non-renewal.

We may terminate this *contract* as of any premium due date if the *member* has not paid the required premium by the end of the Grace Period, as defined in the Grace Period provision. The *member* is liable to *us* for any unpaid premium for the time the Plan was in force.

Upon termination of coverage, *we* will have no further liability for the payment of any *covered services* provided after the date of the *member's* termination.

Plan Termination Due to Non-Payment of Premium

If the required monthly premium is not received by the end of the thirty (30) day grace period, *we* will terminate this contract, without prior notification, retroactive to the last date for which premium was received, subject to the Grace Period provision. Termination will be effective as of midnight of the date that the premium was due provided *we* mail written notice of termination to the member prior to forty-five (45) days after the date the premium was due.

Termination of Coverage

We may terminate coverage for any of the following reasons:

1. Nonpayment of premiums provided that the grace period has elapsed.
2. Coverage is rescinded.
3. The date *we* receive a request from *you* to terminate this *contract*, or any later date stated in *your* request.

4. The date *we* decline to renew this *contract*, as stated in the Discontinuance provision.
5. The date of *your* death.
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 *covered person's* eligibility for insurance under this *policy* ceases due to losing network access as the result of a permanent move.

Terms of Renewal

We guarantee the *member* the right to renew the contract each year, at the *member's* option. However, *we* may refuse to renew this contract, and all coverage provided under this contract, if one of the following circumstances has occurred:

1. The *member* fails to timely pay premium in accordance with the terms of the *contract*;
2. *We* cease offering this contract to all *members*;
3. The *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this *contract*;
4. The *member* no longer lives or works in *our* geographic service area; and
5. *We* elect to discontinue all individual health coverage in the State of Florida.

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

Reinstatement

If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by *us*, or by an agent authorized to accept payment without requiring an application for reinstatement, will reinstate this policy. If *we* or *our* agent require an application, *you* will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 45th day after the date of the conditional receipt unless *we* have previously written *you* of its disapproval. The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement or sickness that starts more than 10 days after such date. In all other respects, *your* right and *ours* will remain the same, subject to any provisions noted on or attached to the reinstated policy. Any premiums *we* accept for a reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days before the reinstatement date.

Discontinuance

180-Day Notice: If *we* discontinue offering and refuse to renew all contracts issued on this form, with the same type and level of benefits, for all residents of the state where *you* reside, *we* will provide a written notice to *you* and all enrollees at least 180 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*, all enrollees, and the Commissioner of Insurance at least 180 days prior to the date that *we* stop offering and terminate all existing individual contracts in the individual market in the state where *you* reside.

Notification Requirements

It is the responsibility of *you* or *your* former *dependent member* to notify *us* within 31 days of *your* legal divorce or *your dependent member's* marriage.

Benefits After Coverage Terminates

If a *network provider* terminates his or her contract with Ambetter from Sunshine Health or is terminated by *us* for any reason other than for cause, a *member* receiving active treatment may continue coverage and care with that *network provider* when *medically necessary* and through completion of treatment of a condition for which the *member* was receiving care at the time of the termination until:

1. The *member* selects another treating provider or during the next open enrollment period, whichever is longer, but not longer than ninety (90) days (or additional if approved by Ambetter from Sunshine Health) after termination of the provider's contracts.
2. The *member* who is pregnant and who has initiated a course of prenatal care regardless of the trimester in which care was initiated, completes postpartum care.

A *network provider* may refuse to continue to provide care to a *member* who is abusive, non-compliant, or in arrears in payment for services provided.

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*.” “Responsible party” includes any parties actually, possibly or potentially responsible for payment of expenses associated with the care or treatment of *third party injuries*.

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. 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 *covered person* 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 *covered person* in connection with the *loss*;
3. To include the amount of benefits paid by *us* on behalf of a *covered person* 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, and regardless of whether such payment will result in a recovery to the *member* which is insufficient to make the *member* whole or to compensate the *member* in part or in whole for the damages sustained);
6. That *we*:
 - a. Will have a lien on all money received by a *covered person* in connection with the *loss* equal to the amount *we* have 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 *covered person* against any *third party* to the extent of the benefits paid on the *covered person’s* behalf; and
 - e. May assert that subrogation right independently of the *covered person*;
7. To take no action that prejudices *our* reimbursement and subrogation rights;

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; and
11. That *we* may reduce other benefits under the *policy* by the amounts a *covered person* has agreed to reimburse *us*.

We have a right to be reimbursed in full regardless of whether or not the *covered person* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

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 *covered person* must reimburse *us*, the *covered person* or the guardian, legal representatives, estate, or heirs of the *covered person* 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.

CLAIMS

Notice of Claim

When a *non-participating provider* renders services, notice of a claim for benefits must be given to *us*. The notice must be in writing, should include the name of the insured and *member* identification number, and any claim will be based on that written notice. The notice must be received by *us* within 20 days after the date of the injury or the first treatment date for the sickness on which the claim is based and may be given to *us* or *your* agent. If this required notice is not given in time, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit the notice within the 20 day period and that notice was given as soon as possible, the claim will not be reduced or invalidated.

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* had no legal capacity to submit such proof during that year.

Cooperation Provision

Each *covered person*, or other person acting on his or her behalf, must cooperate fully with *us* to assist *us* in determining *our* rights and obligations under the *policy* 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; and
4. Furnish any other information, aid or assistance that *we* may require, including without limitation, assistance in communicating with any person or entity, including requesting any person or entity to promptly provide to *us*, or *our* representative, any information, records or documents requested by *us*.

If any *covered person*, 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 *policy*.

In addition, failure on the part of any *covered person*, 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 *covered person*.

Time for Payment of Claims

Benefits will be paid as soon as *we* receive proper *proof of loss*. *We* will reimburse all claims or any portion of any claim within 45 days after receipt of the claim. If a claim or a portion of a claim is contested, *you* or *your* assignees shall be notified, in writing, that the claim is contested or denied, within 45 days after *we* receive the claim from *you*. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim. Upon receipt of the additional information requested *you* or *your* assignees, *we* shall pay or deny the contested claim or portion of the contested claim, within 60 days.

"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.

We shall pay or deny any claim no later than 120 days after receiving the claim. Payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery. All overdue payments shall bear simple interest at the rate of 10 percent per year.

Upon *your* written notification, *we* will investigate any claim of improper billing by a *physician, hospital, or other health care provider*. *We* will determine if *you* were properly billed for only those procedures and services that the *covered person* actually received. If *we* determine that *you* have been improperly billed, *we* shall notify *you* and the provider of *our* findings and shall reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such notification by *us*, *we* shall pay to *you* 20 percent of the amount of the reduction up to \$500.

Payment of Claims

We may elect to pay, in *our* discretion, all or any part of the benefits provided by this contract for *hospital, surgical, nursing, or medical services*, directly to the *hospital or other party providing such services to you*. By reserving the right to pay, in *our* discretion, all or any part of the benefits provided for in this contract directly to a *hospital or other person providing surgical, nursing, or medical services to you*, *we* are not granting any *hospital or other person rendering surgical, nursing or medical services* any right to demand direct payment or any right to enforce any provision of this contract; nor are *we* waiving the Non-Assignment provision of this contract set forth below.

Except as set forth in this provision, all benefits are payable to *you*. Any accrued benefits unpaid at *your* death, or *your dependent'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's* estate, or to a beneficiary who is a minor or is otherwise not competent to give valid release, *we* may pay up to \$3,000 to any relative who, in *our* opinion, is entitled to it.

Foreign Claims Incurred For Emergency Care

Claims incurred outside of the United States for *emergency care and treatment of a covered person* 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.

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.

Medicaid Reimbursement

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

We will pay the benefits of this *policy* to the state if:

1. A *covered person* 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 expenses* under that program.

Our payment to the state will be limited to the amount payable under this *policy* for the *covered 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 *covered person*, 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 *policy*;
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 *covered person* 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 five years after the date *proof of loss* is required.

Prior to initiating any action at law, you are encouraged to first complete all the steps in the complaint/grievance/appeal procedures made available to resolve disputes in Florida under the contract. After completing that complaint/grievance/appeal procedures process, if you want to bring legal action against us on that dispute, you must do so within one year of the date we notified you of the final decision on your complaint/grievance/appeal.

GRIEVANCE AND COMPLAINT PROCEDURES

Applicability/Eligibility

The internal *grievance* procedures apply to any *hospital* or medical policy or certificate, but not to accident only or disability only insurance.

We hope *you* will always be happy with *us* and *our* providers. If *you* are not happy, please let *us* know. Ambetter from Sunshine Health has steps for handling problems *you* may have. Ambetter from Sunshine Health offers all of *our members* the following ways to get *member* satisfaction:

- Complaint
- Internal Grievance process
- Internal Appeal process
- External Appeal process

Complaint

A complaint is the lowest form of problem. It gives Ambetter from Sunshine Health the opportunity to resolve *your* problem without it becoming a formal grievance. Complaints are generally resolved within 3 business days following receipt of the issue. If *you* are not satisfied with the status of the complaint, *you* can request that *your* complaint be moved to the formal grievance system.

Grievance

A grievance is an expression of dissatisfaction about any matter other than an “action”. Filing a grievance will not affect *your* healthcare services. We will not treat *you* differently. We want to know *your* concerns so we can improve *our* services.

Appeal

An appeal is a request to review a Notice of Adverse Benefit Determination or a claim that has been denied in whole or part.

Internal Complaint Process

To file a complaint with Ambetter from Sunshine Health, please contact *our* Member Services Department at 877-687-1169 or TDD/TTY: 800-955-8770.

We will need the following information:

- *Your* first and last name;
- *Your* Ambetter from Sunshine Health ID number;
- *Your* address and telephone number;
- What *you* are unhappy with;
- What *you* would like to have happen.

Complaints

Basic elements of a *complaint* include:

1. The complainant is the claimant or an authorized representative of the claimant;
2. The submission may or may not be in writing;
3. The issue may refer to any dissatisfaction about:
 - a. *Us* (as the insurer); e.g., Member Service *complaints* - “the person to whom I spoke on the phone was rude to me”.
 - b. Providers with whom *we* have a direct or indirect contract.
 - i. Lack of availability or accessibility of *network* providers not tied to an unresolved benefit denial.

Note: When the dissatisfaction is related to services from or access to a *network* provider, notify the Network Administration Department.

- ii. Quality of care/quality of service issues;
4. Written expressions of dissatisfaction regarding quality of care/quality of service are processed as *grievances*.
5. Oral expressions of dissatisfaction regarding quality of care/quality of service are processed as *complaints* as indicated in standard oral *complaint* instructions; and
6. Any of the issues listed as part of the definition of *grievance* received from the *claimant* or the claimant's authorized representative where the caller has not submitted a written request but calls *us* to escalate their dissatisfaction and request a verbal/oral review.

Complaints received from the Florida Office of Insurance Regulation

The Commissioner may require *us* to treat and process any *complaint* received by the Florida Office of Insurance Regulation by, or on behalf of, a claimant as a *grievance* as appropriate. *We* will process the Florida Office of Insurance Regulation *complaint* as a *grievance* when the Commissioner provides *us* with a written description of the *complaint*.

Internal Grievance Process

A grievance may be filed orally or in writing within 365 days of the event. *We* can be reached Monday through Friday, 8:00 am to 8:00 pm by calling Member Services at 877-687-1169 or TDD/TTY: 800-955-8770.

We will need the following information:

- *Your* first and last name;
- *Your* Ambetter from Sunshine Health ID number;
- *Your* address and telephone number;
- What *you* are unhappy with;
- What *you* would like to have happen.

If *you* file a grievance, the Grievance & Appeal Coordinator will send *you* a letter within 5 business of receipt letting *you* know that *we* have received *your* grievance. If *you* have any more information to help with *your* grievance, *you* may send it to us. *We* will add it to *your* case. *You* may send *us* the information at:

Ambetter from Sunshine Health
Grievance and Appeal Coordinator
1301 International Parkway, Suite 400
Sunrise, FL 33323
Phone: 877-687-1169 or TDD/TTY: 800-955-8770
Fax: 866-534-5972
Email: Sunshine_Appeals@centene.com

In some cases, obtaining information to help *us* review *your* grievance may take extra time. The time for deciding *your* grievance can be extended for 14 days if *you* think extra time to get information will benefit *you*. If Ambetter from Sunshine Health requests more time to gather the information, *we* will send *you* a letter to tell *you* why. *We* will only do this if the information *we* are waiting for could help with *your* grievance.

You may ask for copies of any information that Ambetter from Sunshine Health used to make the decision about *your* care.

You can expect a resolution and written answer from Ambetter from Sunshine Health within 30 days of receiving *your* grievance.

Internal Appeal Process

An appeal is a request to review a Notice of Adverse Benefit Determination (NABD). *You* can request this review by phone or in writing. *You* must follow a request by phone in writing within 10 days of the request, unless it is an expedited appeal. A request for an appeal must be received within 180 days of the date of the notice of action letter.

An adverse decision can be when Ambetter from Sunshine Health:

- Denies the care requested;
- Decreases the amount of care;
- Ends care that has previously been approved;
- Denies payment for care and *you* may have to pay for it.

You will know that Ambetter from Sunshine Health is taking action because *we* will send *you* a letter. The letter is called a **Notice of Action**. If *you* do not agree with the action, *you* may request an **Appeal**.

Expedited Appeals

You or *your* doctor may want *us* to make a fast decision. *You* can ask for an expedited review if *you* or *your* doctor feel that *your* health is at risk. *Your* doctor must send information in writing telling *us* why *you* need a faster review. Expedited appeal reviews are available for *members* in situations deemed urgent. If Ambetter from Sunshine Health agrees that the request is urgent, *your* appeal will be resolved within 72 hours.

Who May File an Appeal?

- *You*, the *member* (or the guardian of a minor *member*).
- A person *you* have authorized to act for *you*.

You must give written permission if someone else files an appeal for *you*. Ambetter from Sunshine Health will include a form with the Notice of Action. Contact Member Services at 1-877-687-1169 or TTY/TDD at 800-955-8770 if *you* need help. *We* can assist *you* with filing an appeal.

When does an Appeal Have to be Filed?

The Notice of Action will tell *you* about this process. ***You may file an appeal, and such appeal must be filed, within 180 days from the date of the Notice of Action.*** If *you* make your request by phone, *you* must also send Ambetter from Sunshine Health a letter confirming *your* request within 10 days of making the request by phone. Ambetter from Sunshine Health will give *you* a written decision within **30 days (if the service has not been provided) or 60 days (if the service has already been provided)** of the date *we* receive *your* written request.

You, or someone authorized to do so, can act for *you* or help *you* with the appeal. *You* can tell *us* the name of the person authorized to help *you* by completing a Request for an Appeal or Grievance Form. *We* can help *you* fill out this form. Call *us* at 877-687-1169 or TTY/TDD at 800-955-8770 to ask for help, including if *you* need an interpreter.

You may send *us* health information about why *we* should pay for the service. This information can be sent with the Request for an Appeal or Grievance Form or in a separate letter. *You* can call *your* doctor if *you* need more medical information for *your* appeal. In some cases, getting the health information may take extra time. The time for deciding *your* appeal can be extended for 14 days if *you* or *your* doctor thinks the extra time to get the health information will benefit *you*. If Ambetter from Sunshine Health requests more time to gather the health information, *we* will send *you* a letter to tell *you* why. This extension will be for 14 days. *We* will only do this if the health information *we* are waiting for could help with *your* plan appeal.

You may send the Request for an Appeal or Grievance Form, or *your* written request for a plan appeal and any health information to *us* by sending a letter to:

Ambetter from Sunshine Health
Grievance and Appeal Coordinator
1301 International Parkway, Suite 400
Sunrise, FL 33323
Fax: 866-534-5972

If the Notice of Action that *you* were sent said that *we* were terminating, suspending, or reducing a service that *you* were getting as an Ambetter from Sunshine Health *member*, *you* have the right to keep getting the service. If *you* let *us* know that *you* want to continue the service within ten (10) days of the Notice of Action letter, *we* will approve *you* to continue this service until the plan appeal decision is made. To do this, Ambetter from Sunshine Health must have been approving *you* to get the service before, the services were ordered by an authorized provider, and the time of the approval for that service has not ended. If after the review of *your* plan appeal Ambetter from Sunshine Health decides that the decision to terminate, suspend, or reduce the service was right and *you* kept getting the service, *you* may have to pay for the service.

You may request these documents by contacting:

Ambetter from Sunshine Health
Grievance and Appeal Coordinator
1301 International Parkway, Suite 400
Sunrise, FL 33323
Phone: 877-689-1167
Fax: 866-534-5972
TTY/TDD: 800-955-8770
Sunshine_Appeals@centene.com

If *you* have questions, call *us* at 877-687-1169 or TDD/TTY at 800-955-8770.

External Review

If *you* are dissatisfied with the Ambetter from Sunshine Health appeal decision, *you* have the right to have an independent review of certain final decisions made by Ambetter from Sunshine Health. Ambetter from Sunshine Health must pay the cost of the Independent Review Organization (IRO) conducting the external review. If *you* request it, an appeal will be conducted by an external review organization called an IRO. An IRO is not connected in any way with Ambetter from Sunshine Health. Ambetter from Sunshine Health must abide by the IRO's decision and carry out its instructions.

You can make a request for external review in writing to **Ambetter from Sunshine Health Plan** at:

Ambetter from Sunshine Health
Appeals Department
1301 International Parkway
Sunrise, FL 33323

If assistance is needed with completing the written request, *you* may contact Ambetter from Sunshine Health at:

Phone 1-877-687-1169
TTY/TDD 800-955-8770
Fax 1-866-534-5972

We will send *your* request to the IRO. *You* must contact the IRO or *us* within 120 calendar days (4 months) of the date of your appeal resolution letter. If *you* do not file *your* appeal for an external independent review within 120 days, it cannot be reviewed. If *you* are not sure whether *your* appeal is eligible, or if *you* want more information, please contact Ambetter from Sunshine Health.

You, or someone *you* authorized to do so, 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.

External Review

Ambetter from Sunshine Health *members* are offered two levels of appeal for *adverse benefit determinations* related to a service that requires medical review. An external review decision is binding on *us*. An external review decision is binding on the claimant except to the extent the claimant has other remedies available under applicable federal or state law. *We* will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility

The external review procedures apply to any *hospital* or medical policy or certificate; excluding accident only or disability income only insurance.

External review is available for *grievances* that involve:

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

After exhausting the internal review process, the claimant can make a written request to the Appeals & Grievance Department for external review after the date of receipt of *our* internal response. *We* will send *your* request to the IRO. *You* must contact the IRO or *us* within 120 calendar days (4 months) of the date of your appeal resolution letter. If *you* do not file *your* appeal for an external independent review within 120 days, it cannot be reviewed. If *you* are not sure whether *your* appeal is eligible, or if *you* want more information, please contact Ambetter from Sunshine Health.

1. The internal appeal process must be exhausted before the claimant may request an external review unless the claimant files a request for an expedited external review at the same time as an internal *expedited appeal* or *we* either provide a waiver of this requirement or fail to follow the appeal process.
2. A health plan must allow a claimant to make a request for an expedited external review with the plan at the time the claimant receives:
 - a. An *adverse benefit determination* if the determination involves a medical condition of the claimant for which the timeframe for completion of an internal *expedited appeal* would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an internal *expedited appeal*.
 - b. A final internal *adverse benefit determination*, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal *adverse benefit determination* concerns an admission,

- availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.
3. Claimants may request an expedited external review at the same time the internal *expedited appeal* is requested and an Independent Review Organization (IRO) will determine if the internal *expedited appeal* needs to be completed before proceeding with the expedited external review.

External Review Process

1. We have five (5) business days (immediately for expedited external review) following receipt of the request to conduct a preliminary review of the request to determine whether:
 - a. The individual was a *covered person* at the time the item or service was requested;
 - b. The service is a *covered service* under the claimant's health plan but for the plan's *adverse benefit determination* with regard to *medical necessity experimental or investigational*, medical judgment, or *rescission*;
 - c. The claimant has exhausted the internal process; and
 - d. The claimant has provided all of the information required to process an external review.
2. Within one (1) business day (immediately for expedited) after completion of the preliminary review, we will notify the claimant in writing as to whether the request is complete but not eligible for external review and the reasons for its ineligibility or, if the request is not complete, the additional information needed to make the request complete. We will include notification of the member's right to submit written testimony to be included in the materials sent to the IRO.
3. We must allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of notification.
4. We will assign an IRO on a rotating basis from our list of contracted IROs.
5. Within five business days after the date of assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO.
Note: For expedited external review, after assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method.
6. If we fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the *adverse benefit determination*.
7. Within 10 business days, the assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the claimant may submit in writing additional information to the IRO to consider.
8. Upon receipt of any information submitted by the claimant, the IRO must forward the information to us within one business day.
9. Upon receipt of the information, we may reconsider our determination. If we reverse our *adverse benefit determination*, we must provide written notice of the decision to the claimant and the IRO within one business day after making such decision. The external review would be considered terminated.
10. Within 45 days (72 hours for expedited external review) after the date of receipt of the request for an external review by the health plan, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to the claimant and to us. If the notice for an expedited external review is not in writing, the IRO must provide written confirmation within 48 hours after the date of providing the notice.
11. Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, we will approve the covered benefit that was the subject of the *adverse benefit determination*.

After you receive a decision from Ambetter by Sunshine Health concerning your benefits and feel further action is needed, you have the right to file a complaint with the Department of Financial Services, Division of Consumer Services.

You may request assistance of the Department of Financial Services, Division of Consumer Services by telephone at 1-877-MY-FL-CFO (1-877-693-5236), or if calling from outside of Florida (1-850-413-3089), by email at ConsumerServices@myfloridacfo.com, or online at: <http://www.myfloridacfo.com/Division/Consumers/>

You, or someone you authorized to do so, 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.

Grievance Panel

The internal process requires that *your* appeal is handled by a grievance panel that does not include the person who made the initial determination or a subordinate of the original reviewer. During the grievance process, the initial decision maker may be consulted. The majority of the panel will consist of providers with the appropriate expertise. The panel must be requested within 30 days after Ambetter from Sunshine Health's transmission of an adverse determination. The panel will also provide a notice to the *member* and to the provider, if any, who filed on behalf of the *member*. In any case where the review process does not resolve a difference of opinion between Ambetter from Sunshine Health and the *member*, the *member* (or provider) may submit a written grievance through an external review process. *Members* may voluntarily pursue binding arbitration (which *you* may incur some costs for this arbitration) after completing Ambetter from Sunshine Health's grievance procedure and as an alternative to the external review process (refer to the External Review section for more information). Arbitration shall not preclude review pursuant to Rule 690-191.081 and shall be conducted pursuant to Ch. 682, F.S.

When the *adverse benefit determination* is based in whole or in part on a medical judgment, the *grievance* panel will consult with a licensed health care provider with expertise in the field relating to the *grievance* and who was not consulted in connection with the original *adverse benefit determination*.

Expedited Appeal

An *expedited appeal* 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.

For an appeal to be processed as expedited at least one of the following must apply:

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*.

An *expedited appeal* provides for evaluation by appropriate clinical peers or peer (who were not involved in the initial adverse determination) within 24 hours. An *expedited appeal* shall be resolved as expeditiously as the *claimant's* health condition requires but not more than 72 hours after receipt of the *appeal*. Written notification of the decision must be provided no later than 2 business days or three calendar days if the initial notification was not in writing.

A *member* has the right to request both an internal and external level expedited appeal, related to the denial of a service requiring medical review, simultaneously. If the expedited appeal is unresolved, the

member may appeal through the external review process (refer to the External Review section for more information).

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 *appeal* is handled.

Written Grievance/Appeal Response

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

The panel's written decision must include:

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

COORDINATION OF BENEFITS

Ambetter from Sunshine Health /coordinates benefits with other payers when a *member* is covered by two or more group 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 from Sunshine Health 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 from Sunshine Health 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.

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

The term "Plan" includes:

1. Group and non-group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group and individual HMO insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.
2. Plan includes medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
3. Plan includes hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid.
4. Plan does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums. Plan does not include coverage, which by law, provides benefits that are in excess of those of any private insurance plan or other nongovernment plan.

"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

The first of the rules listed below in paragraphs 2-9 that applies will determine which plan will be primary:

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. If the person receiving benefits is the *member* and is only covered as an *eligible dependent* under the other plan, this *contract* will be primary.
4. However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a dependent of an active employee (a Medicare beneficiary also has another group plan), then the order of benefit determination is:
 - a. First, benefits of a plan covering a person as an employee, member, or subscriber.
 - b. Second, benefits of a plan of an active worker covering a person as a dependent;
 - c. Third, Medicare benefits.
5. 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 year (excluding year of birth) shall be primary.
 - a. If both parents have the same birthday, the plan which covered the parent longer will be primary.
 - b. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.
6. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
 - a. The plan of the parent who has custody will be primary;
 - b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
7. If a child's coverage is based on a court decree, and the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child and if the entity obliged to pay or provide the benefits of the policy or plan of that parent has actual knowledge of those terms, the benefits of that policy or plan are determined first. The parent with responsibility that has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan.
8. If the person receiving services is covered under one plan as an active employee or *member* (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.

9. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

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.

In the event of multiple forms of coverage, Ambetter reserves the right to reduce or refuse to pay benefits otherwise payable on the account of existing of similar benefits provided under insurances policies issued by the same or another insurer, in accordance with state and federal laws. As a condition of coordinating benefits, the insurers together pay 100 percent of the total reasonable expenses actually incurred of the type of expense within the benefits described in the policies and presented to the insurer for payment.

Effect of Medicare

Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status, and will be adjudicated by us as set forth in this section. When Medicare, Part A and Part B or Part C is primary, Medicare's allowable amount is the highest allowable expense.

Members 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.

GENERAL PROVISIONS

Entire Contract

This *contract*, with the application and any rider-amendments is the entire *contract* between *you* and *us*. No party or agent of a party may:

1. Change or alter the terms of this *contract*;
2. Waive any provision of this *contract*;
3. Extend the time for payment of premiums;
4. Waive any of *our* rights or requirements under the *contract*; or
5. Waive any of your obligations under the *contract*.

Non-Waiver

If *we* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *policy*, which will not be considered a waiver of any rights under the *policy*. A past failure to strictly enforce the *policy* 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 *covered person* during the application process that relates to insurability will be used to void/rescind the insurance coverage or deny a claim unless:

1. The misrepresented fact is contained in a written application, including amendments, signed by a *covered person*;
2. A copy of the application, and any amendments, has been furnished to the *covered person(s)*, or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *covered person*. A *covered person'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.

We will provide the *covered person* forty-five (45) days advance written notice before coverage is rescinded.

Time Limit on Certain Defenses

Relative to a misstatement in the application, after 2 years from the issue date, only fraudulent misstatements in the application may be used to void the *policy* or deny any claim for loss incurred or disability starting after the 2-year period.

Repayment for Fraud, Misrepresentation or False Information

During the first two years a *covered person* is insured under the *policy*, if a *covered person* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *covered person* under this *policy* or in filing a claim for *policy* benefits, *we* have the right to demand that *covered person* pay back to *us* all benefits that *we* paid during the time the *covered person* was insured under the *policy*. *We* will return any premium paid during the time period for which the *covered person* returned benefit payments.

Construction

We have the full power, authority, and discretion to construe and interpret any and all provisions of this *contract* to the greatest extent allowed by applicable law.

Conformity with State Laws

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

Performance Outcomes and Financial Data

You may obtain information regarding performance outcomes and financial data for Celtic Insurance Company published by the State of Florida Agency for Health Care Administration by accessing Ambetter from Sunshine Health's website: Ambetter.SunshineHealth.com. This website includes the link to FloridaHealthStat where this information is published.