ambetter. FROM coordinated care

# 2020 Evidence of Coverage

Ambetter.CoordinatedCareHealth.com

61836WA009-2020

# COORDINATED CARE CORPORATION

Home Office: **1145 Broadway, Suite 300, Tacoma, WA 98402**

Individual Member HMO Contract
Ambetter from Coordinated Care

Coordinated Care Corporation is a health maintenance organization (HMO) providing healthcare coverage for Members. In this Contract, the terms "you", "your" or "yours" refer to the Member or any dependents enrolled in this Contract. The terms "we," "our" or "us" refer to **Coordinated Care Corporation** or **Ambetter from Coordinated Care**.

## AGREEMENT AND CONSIDERATION

This document along with the corresponding Schedule of Benefits is your Contract and it is a legal document. It is the agreement under which benefits will be provided and paid. In consideration of your application and timely payment of premiums, we will provide healthcare benefits to you, the Member, for Covered Services as outlined in this Contract. Benefits are subject to Contract definitions, provisions, limitations and exclusions.

## GUARANTEED RENEWABLE

Annually, we must file this product, the Cost Share and the rates associated with it for approval. Guaranteed renewable means that your plan will be renewed into the subsequent year's approved product on the anniversary date unless terminated earlier in accordance with Contract terms. You may keep this Contract (or the new Contract you are mapped to for the following year) in force by timely payment of the required premiums. In most cases you will be moved to a new Contract each year, however, we may decide not to renew the Contract as of the renewal date if: (1) we decide not to renew all Contracts issued on this form, with a new Contract at the same metal level with a similar type and level of benefits, to residents of the state where you then live; (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 fails to pay any Deductible or Copayment Amount owed to us and not the Provider of services; (3) a Member is found to be in material breach of this Contract; or (4) 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.

## TEN DAY RIGHT TO RETURN CONTRACT

Please read your Contract carefully. If you are not satisfied, return this Contract to us or to our agent within 10 days after you receive it. All premiums paid will be refunded, and the Contract will be considered null and void from the Effective Date. If we do not refund payments within thirty (30) days of timely receipt of the returned Contract, we will pay a penalty of ten percent (10%) of such premium. We may reduce the refund by the value of services received during the period to which the refund applies.

Coordinated Care Corporation
Beth Johnson
CEO and Plan President

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# INTRODUCTION

Welcome to **Ambetter from Coordinated Care**! We have prepared this Contract to help explain your coverage. Please refer to this Contract whenever you require medical services. It describes:

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

This Contract, the Schedule of Benefits, the application as submitted to the Exchange or the application as submitted to Coordinated Care (if purchasing a Contract outside the Exchange), and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided or paid for by us.

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

**How to Contact Us**
Ambetter from Coordinated Care
1145 Broadway, Suite 300
Tacoma, WA 98402

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. PST, Monday through Friday

Member Services **1-877-687-1197**
TTY/ TDD line **1-877-941-9238**

Fax **877-941-8078**
Substance Use/Mental Health **1-877-687-1197**
24/7 Nurse Advice Line **1-877-687-1197**

**Other Important Phone Numbers**
Vision Benefits **1-877-687-1197**
Pharmacy Benefits **1-877-687-1197**
Emergency **911**

**Interpreter Services**
Ambetter from Coordinated Care has a free service to help Members who speak languages other than English. These services ensure that you and your Physician can talk about your medical or behavioral health concerns in a way that is comfortable for you.

Our interpreter services are provided at no cost to you. We have medical interpreters to assist with languages other than English via phone. An interpreter will not go to a Provider's office with you, except under certain circumstances. Members who are blind or visually impaired and need help with interpretation can call Member Services for oral interpretation, or to request materials in Braille or large font.

To arrange for interpreter services, please call Member Services at 1-877-687-1197 or for the hearing impaired TTY/ TDD 1-877-941-9238.

# MEMBER RIGHTS AND RESPONSIBILITIES

**We are committed to:**

1. Recognizing and respecting you as a Member.
2. Encouraging open discussions between you, your Physician, and other Medical Practitioners.
3. Providing information to help you become an informed healthcare consumer.
4. Providing access to Covered Services and our Network Providers.
5. Sharing our expectations of you as a Member.
6. Providing coverage regardless of age, ethnicity, race, religion, gender, sexual orientation, national origin, physical or mental disability, and/or expected health or genetic status.

These rights and responsibilities are further detailed in the sections throughout this Contract. Please see applicable sections for additional information.

**You have the right to:**

1. Participate with your Physician and Medical Practitioners in decisions about your healthcare. This includes working on any treatment plans and making care decisions. You should know any possible risks of various treatment options you may have, problems related to recovery, and the likelihood of success. You shall not have any treatment without consent freely given by you or your legally authorized surrogate decision-maker. Your Provider should inform you of your care options.
2. Know who is approving and performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which you have coverage. Coverage requires the use of in-network Providers as explained in this document. Failure to utilize Network Providers without Prior Authorization, except for Emergency Services, may result in denial of benefits.
4. Be treated with respect and dignity.
5. Privacy of your personal health information, consistent with state and federal laws, and our policies.
6. Receive information, about our organization and services, our Network of Physicians and Medical Practitioners, changes in Network status for Providers who you are receiving treatment from, and our policies.
7. Candidly discuss with your Physician and Medical Practitioners appropriate and Medically Necessary care for your condition, including new uses of technology, regardless of cost of such services or whether the services are part of your benefit coverage. This includes information from your Primary Care Provider about what might be wrong (your diagnosis), recommended treatment and other available options, and the most likely results (your prognosis). Your Provider and our Ambetter Member Services department can discuss treatments with you that may or may not be covered by the plan, regardless of the cost. You have a right to know about any costs you will need to pay. This should be told to you in words you can understand. When it is not appropriate to give you information for medical reasons, the information can be given to a legally authorized person. Your Physician will ask for your approval for treatment unless there is an emergency and your life and health are in serious danger.
8. Voice Complaints or Grievances about our organization, your coverage, or care provided.
9. Appeal any benefit or coverage decisions we (or our designated administrators) make.
10. Refuse treatment for any condition, illness or disease without jeopardizing future treatment to the extent the law allows. You are responsible for your actions if treatment is refused or if the Provider's instructions are not followed. You should discuss all concerns about treatment with your Provider and be informed by your Physician(s) of the medical consequences. Your Provider can discuss different treatment plans with you, if there is more than one plan that may help you. You will make the final decision. Your Provider should provide you with information on Advance Directives and you

should ask that a copy be kept in your medical chart.

11. See your medical records.
12. You have the right to be informed of covered and non-covered services when you request information or Authorization for services; how to access services; how to choose and/or change your Primary Care Provider assignment; which Providers are in-network; how to file an Appeal if you receive a benefit denial; and how to file a Grievance. This includes information on Member rights and responsibilities, and our other rules and guidelines. We will notify you at least 30 days before the Effective Date of any modifications. Any notices will let you know about the effect of any changes on your coverage and any personal liability related to benefits or costs.
13. Select another health plan or switch health plans during open enrollment or a special enrollment period.
14. Adequate access to qualified Physicians and Medical Practitioners and treatment or services regardless of age, race, sex, sexual orientation, family structure, geographic location, health condition, national origin or religion.
15. Access Medically Necessary urgent and Emergency Services 24 hours a day and seven days a week.
16. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.
17. Select your Primary Care Provider within the Network. You also have the right to change your Primary Care Provider or request information on Network Providers close to your home or work.
18. Know the name and job title of people providing you care.
19. An interpreter, available by phone, if you do not speak or understand English.
20. A second opinion by a Network Provider, if you want more information about your treatment or would like to explore additional treatment options.
21. Make an Advance Directive for healthcare decisions. Your Provider should provide you with information on Advance Directives and you should ask that a copy be kept in your medical chart.
22. Advance Directives are forms you can complete to protect your rights for medical care. It can help your Primary Care Provider and other Providers understand your wishes about your health. Advance Directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself. Examples of Advance Directives include:
    a. Living Will
    b. Healthcare Power of Attorney
    c. "Do Not Resuscitate" Orders

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

**You have the responsibility to:**

1. Read this entire Contract.
2. Treat all healthcare professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about your health. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your Physician until you understand the care you are receiving.
4. Review and understand the information you receive about us. You need to know the proper use of Covered Services, including the need to use Network Providers and obtain Prior Authorization for services when required.
5. Show your I.D. card and keep scheduled appointments with your Physician, and call the Physician's office during office hours whenever possible if you have a delay or cancellation.
6. See your assigned Primary Care Provider for most of your care. You may change your Primary Care

Provider verbally or in writing by contacting our Member Services Department.

7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
8. Understand your health problems and participate, along with your healthcare professionals and Physicians in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that we and/or your healthcare professionals and Physicians need in order to provide care.
10. Follow the treatment plans and instructions for care that you have agreed on with your healthcare professionals and Physician.
11. Tell your healthcare professional and Physician if you do not understand your treatment plan or what is expected of you. You should work with your Provider to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when you think you have an Emergency Medical Condition. For all other care, you should call your Primary Care Provider or access an Urgent Care Center. You also have access to our 24/7 Nurse Advice Line at 1-877-687-1197 and may be able to access Telemedicine services through your Provider or by calling 1-800-835-2362.
14. Provide us with information about any other health care coverage you obtained before or after enrolling with us. If you enroll in other coverage, you must provide us with the information as soon as possible. This is to avoid improper payments. You cannot enroll in Marketplace Coverage if you already have Medicare coverage. Marketplace Coverage is duplicative for existing Medicare Members, and will not provide additional benefits because Medicare is primary.
15. Pay your monthly premiums on time and pay all Deductible Amounts, Copayment Amounts, or Coinsurance percentages.
16. Receive all of your healthcare services and supplies from Network Providers, except as specifically stated in this Contract.
17. Inform the Washington Health Benefit Exchange or other entity through which you enrolled of any changes to your income, household size, address or health coverage eligibility as soon as possible, but no more than 60 days from the date of the event.

# IMPORTANT INFORMATION

**Provider Directory**
A list of our Network Providers is available online at Ambetter.CoordinatedCareHealth.com. Ambetter from Coordinated Care's Provider Network in Washington State is named "CCCWA Exchange." Network Providers listed on the CCCWA Exchange include Physicians, Hospitals, and other Medical Practitioners who have agreed and are contracted to provide Ambetter Members with required medical treatment and healthcare services. You can find our Network Providers by visiting our website and using the "Find a Provider" tool. For information about receiving care outside of Washington Service Area or outside of Washington State, please see the Service Area section in Access to Care.

You can search for a Provider by name or, if you click on the Type of Provider, you can search for Hospital Providers, Primary Care Providers, Specialists, pharmacies or other Providers. You can also narrow your search by Provider specialty, zip code, gender, whether or not they are accepting new patients, and languages spoken. Your search will produce a list of Providers based on your search criteria and includes other information such as address and phone number. Once you pull up a listing of Providers, if you click on the Provider name, you can get more details including office hours, if they are accepting new patients and other information.

You can request a printed copy of the Provider directory at no charge by calling Member Services at 1-877-687-1197. In order to obtain benefits, you must designate a Primary Care Provider (PCP) for each Member. Otherwise, we will automatically assign a PCP in your area. We can help you pick a PCP if needed. We will make your choice of PCP effective on the next business day, if the selected Physician's caseload permits. We will notify you if your PCP leaves our Network. You will be able to see that PCP for at least sixty (60) days from that notice.

If you have difficulty locating a Primary Care Provider, Specialist, Hospital or other contracted Provider please contact us so we can assist you with access or in locating a contracted Ambetter Provider. Ambetter Physicians may be affiliated with different Hospitals. Our online directory can provide you with information on the Ambetter contracted Hospitals. The online directory also lists affiliations that your Provider may have with non-contracted Hospitals. Your Ambetter coverage requires you to use contracted Providers with limited exceptions.

Call the Provider's office if you want to make an appointment. If you need help, call Member Services at 1-877-687-1197.

**Member ID Card**
When you enroll, we will mail a Member ID card after we receive your completed enrollment materials and you have paid your initial premium payment. You need to keep this card with you at all times. Please show this card every time you go for any service under the Contract. The ID card will show your name, Member ID number, the phone numbers for Member Services, pharmacy and 24/7 Nurse Advice Line, and Copayment Amounts required at the time of service. If you do not get your ID card within a few weeks after you enroll, please call Member Services at 1-877-687-1197. We will send you another card.

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

1. Finding a Network Provider.
2. A secure portal for you to check the status of your Claims, make payments and obtain a copy of your Member ID card.

3. Our programs and services, including programs to help you get and stay healthy.
4. Member Rights and Responsibilities.
5. Notice of Privacy.
6. Current events and news.
7. Deductible and Copayment accumulators.
8. Our Formulary or Preferred Drug List.
9. Selecting a Primary Care Provider.

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

1. Conducting a thorough check on Providers when they become part of the Provider Network.
2. Providing programs and educational items about general healthcare and specific diseases.
3. Sending reminders to Members to get annual tests such as a physical exam, cervical cancer screening, breast cancer screening, and immunizations.
4. A Quality Improvement Committee which includes Network Providers to help us develop and monitor our program activities.
5. Investigating any Member concerns regarding care received.

If you have a concern about the care you received from your Network Provider or service provided by us, please contact the Member Services Department.

We believe that getting Member input can help make the content and quality of our programs better. We conduct a Member survey, typically on an annual basis, that asks questions about your experience with the healthcare and services you are receiving.

**Protection from Balance Billing**
Under the Washington Balance Billing Protection Act, effective January 1, 2020, Non-Network Providers or Facilities in Washington State are prohibited from Balance Billing health plan Members for:

1. Emergency Services provided to a Member; or
2. Non-emergency health care services provided to a Member at a Network Hospital or at a Network ambulatory surgical Facility if the services:
    a. involve Surgical or Ancillary Services; and
    b. are provided by a Non-Network Provider.

Please review the Access to Care and Covered Services sections of this Contract for detailed information.

# DEFINITIONS

Wherever used in this Contract:

**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.

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

**Adverse Benefit Determination** or **Adverse Determination** is any decision we make that results in a denial, reduction, termination of, or failure to provide or make payment, in whole or in part, for a benefit. This includes determinations:

1. Based on a Member's or applicant's eligibility to participate in an Ambetter plan, including denial of an application for coverage.
2. That an item or service is Experimental or Investigational, or not Medically Necessary or appropriate.
3. Resulting from the application of any Utilization Review, including eligibility, medical necessity, appropriateness, health care setting, level of care, effectiveness, and Experimental or Investigational determinations.
4. Resulting from a prospective or retrospective review.
5. Resulting from a Claim or Appeal denial.
6. Regarding Rescission of coverage.

Please refer to the Grievance and Appeals Process section of this Contract for information about 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, including any applicable Member Cost Sharing responsibility, for a Covered Service received from either a Network or Non-Network Provider. 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 in full for that particular service. In all cases, the Allowed Amount includes any Cost Sharing owed by the Member (e.g., Deductible, Coinsurance and Copayment).

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. This is known as Balance Billing – see Balance Billing and Non-Network Provider definitions for additional information.

**Ambulatory Services** means healthcare services delivered at a Provider's office, clinic, medical center or Ambulatory Surgery Center in which the patient's stay is not longer than 24 hours.

**Ambulatory Surgery Center** or **Ambulatory Surgical Center** means a Facility, licensed by the state in which it is located, that is equipped and operated mainly for Surgeries or obstetrical deliveries that allow patients to leave the Facility the same day the Surgery or delivery occurs.

**Appeal** means a written or verbal request from a Member or the Member's Authorized Representative, that we reconsider an Adverse Benefit Determination or decision we made regarding:

1. Access to healthcare benefits;
2. Admission to or continued stay in a healthcare Facility;
3. Claims payment, handling or reimbursement for healthcare services;
4. Matters pertaining to our contractual relationship with a Member;
5. Cancellation of your benefit coverage by us; and
6. Any matters specifically required by state law or regulation.

Please refer to the Grievance and Appeals Process section of this Contract for detailed information about your Appeal rights, including how to file an Appeal and who may file an Appeal on your behalf.

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

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

**Authorization** or **Authorized** (also **Prior Authorization**) means our decision to approve the medical necessity or the appropriateness of care for a Member requested by the Member's PCP or Provider group before the Member receives services.

**Authorized Representative** means an individual who represents a Member in an internal Appeal or External Review process of an Adverse Benefit Determination who is any of the following:

1. A person to whom a 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;
2. A person authorized by law to provide substituted consent for a covered individual; or
3. A family member or a treating health care professional, but only when the Member is unable to provide consent.

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

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

**Balance Billing** is when a Non-Network Provider bills a Member for health care services provided to the Member after the Provider or Facility's Billed Amount is not fully reimbursed by the health plan, exclusive of permitted Cost Sharing.

**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.

**Brand Name Medication** or **Brand Name Drug** means a medication sold by a pharmaceutical company under a trademark-protected name. Brand Name Medications can only be produced and sold by the company that holds the patent for the drug.

**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 healthcare 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 Provider.

**Chemical Dependency** means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under the Uniform Controlled Substance Act and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or the user's social or economic function is substantially disrupted.

**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.

**Claim** means a request by a Provider to be compensated by us for services provided to a Member. Typically, the Provider will submit a Claim to us; however, if you see a Non-Network Provider, you may need to send us the Claim. Approval and payment of Claims is subject to the Member's benefits, eligibility, and Cost Sharing. See additional information in the Claims section of this Contract.

**Coinsurance** means the part of Covered Service expenses that you are required to pay when you receive a service. Coinsurance amounts are listed in the Schedule of Benefits. Not all Covered Services have Coinsurance.

**Complaint** means any expression of dissatisfaction by you or your Authorized Representative to us that is about us or Providers with whom we have a direct or indirect contract.

**Complications of Pregnancy** means:

1. Conditions whose diagnoses are distinct from Pregnancy, but are adversely affected by Pregnancy or are caused by Pregnancy and not, from a medical viewpoint, associated with a normal Pregnancy. This includes but is not limited to: fetal distress, gestational diabetes, toxemia, ectopic Pregnancy, spontaneous abortion, preeclampsia, eclampsia, missed abortion, false labor, edema, morning sickness and similar medical and surgical conditions of comparable severity.
2. An emergency caesarean section or a non-elective caesarean section.

**Contract** refers to this Contract, as issued and delivered to you.

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

**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** or **Cost Share** means the part of the costs you are responsible to pay for your insurance coverage, including the Deductible Amount, Copayment Amount and Coinsurance that you pay for Covered Services listed in the Schedule of Benefits. Cost Sharing does not include premiums, Balance Billing amounts for Non-Network Providers or the cost of non-covered services.

**Cost-Sharing Reductions** lower the amount you have to pay in Deductibles, Copayments and Coinsurance. To qualify for Cost-Sharing Reductions, an eligible individual must enroll in a silver level plan through the Exchange or be a member of a federally recognized American Indian tribe and/or an Alaskan Native enrolled in a QHP through the Exchange.

**Covered Services** are healthcare services, supplies or treatment described in this Contract that are performed, prescribed, directed or Authorized by a Physician or Medical Practitioner, and are:

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

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

Custodial Care includes but is not limited to the following:

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

**Deductible** or **Deductible Amount** is 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 which is two times the individual Deductible. Both the individual and the family Deductibles 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 when:

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

If you satisfy your individual Deductible, each of the other Members of your family are still responsible for the Deductible until the family Deductible is satisfied for the calendar year.

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

**Dependent Member** means your lawful Spouse, state registered domestic partner as required by Washington law, and/or an Eligible Child.

**Drug Discount**, **Coupon or Copay Card** means cards or coupons typically provided by a drug manufacturer to discount the Copay or your other Out-of-Pocket Expenses (e.g., Deductible or Maximum Out-of-Pocket).

**Durable Medical Equipment** means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an illness or injury, can withstand repeated use, are generally not useful to a person in the absence of illness or injury, and are appropriate for use in the patient's home. It shall also include sales tax under any benefit for Durable Medical Equipment that is a Covered Service and when equipment is not tax exempt.

**Effective Date** means the date a Member becomes covered under this Contract for Covered Services. The applicable Effective Date is:

1. The same date as your initial coverage date; and
2. The date we approve the addition of any new Member.

**Eligible Child** means the child of a Covered Person, if that child is less than 26 years of age. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child;
3. A child for whom you have assumed a legal obligation for total or partial support in anticipation of adoption;
4. A step child for whom the Member has a qualified court order to provide coverage; or
5. A child for whom legal guardianship has been awarded to you or your Spouse.

It is your responsibility to notify the entity with which you enrolled (either the Exchange or us) if your child ceases to be an Eligible Child. You must reimburse us for any benefits that we provide or pay for a child at a time when the child did not qualify as an Eligible Child.

A Member will not cease to be a dependent Eligible Child solely beyond the 26th birthday if the Eligible Child is and continues to be both:

1. Incapable of self-sustaining employment by reason of developmental disability or physical handicap, and;
2. Chiefly dependent on the primary Member for support and maintenance.

**Eligible Service Expense** (see **Allowed Amount** definition).

**Emergency Medical Condition** means a medical, mental health or Substance Use Disorder condition showing severe symptoms (including severe pain) such that an average person, who possesses common knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health or Substance Use Disorder treatment attention to result in:

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

**Emergency Services** means a medical screening examination that is within the capability of the emergency department of a Hospital, including Ancillary Services routinely available to the emergency department to evaluate that Emergency Medical Condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and Facilities available at the Hospital to stabilize the patient. Stabilize, with respect to an Emergency Medical Condition, means to provide medical treatment of the condition as necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer or discharge of the individual from a Facility, or, with respect to an Emergency Medical Condition as defined.

**Essential Health Benefits** are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Use Disorder services, including behavioral health treatment; Prescription Drugs; Rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (services covered for a Member until the end of the month they reach the age of 19), including oral and vision care. Essential Health Benefits provided within this Contract are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or annual dollar maximum.

**Exchange** refers to the Washington Health Benefit Exchange established under chapter 43.71 of the Revised Code of Washington (RCW). This is the online marketplace to purchase health insurance coverage in Washington.

**Expedited Appeal** is a request for expedited review and determination of an Appeal. You or your Provider may file an Expedited Appeal if:

1. You are currently receiving or are prescribed treatment for a medical condition, and your treating Provider believes the application of standard Appeal timeframes for a pre-service or concurrent care Claim could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject you to severe and intolerable pain; or
2. The Appeal concerns an issue related to admission, availability of care, continued stay or healthcare services received on an emergency basis where you have not been discharged.

**Experimental** or **Investigational** means that a service is considered Experimental or Investigational for a Member's condition if any of the following statements apply to it at the time the service is or will be provided to the Member:

1. The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted.
2. The service is the subject of a current new drug or new device application on file with the FDA.
3. The service is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity or effectiveness of the service.
4. The service is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity or efficacy as among its objectives.
5. The service is under continued scientific testing and research concerning the safety, toxicity or effectiveness of services.
6. The service is provided pursuant to informed consent documents that describe the service as Experimental or Investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity or efficacy.
7. The prevailing opinion among experts, as expressed in the published authoritative medical or scientific literature, is that (1) the use of such service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity or efficacy of the service.

In determining whether services are Experimental or Investigational, we will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious.

The following sources of information will be exclusively relied upon to determine whether a service is Experimental or Investigational. This information will be made available for inspection upon the written request of the Member and will not be withheld as proprietary:

1. The Member's medical records,
2. The written protocol(s) or other document(s) pursuant to which the service has been or will be provided,
3. Any consent document(s) the Member or Member's representative has executed or will be asked to execute, to receive the service,
4. The files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,
5. The published authoritative medical or scientific literature regarding the service, as applied to the Member's illness or injury, and
6. Regulations, records, applications and any other documents or actions issued by, filed with or taken by, the FDA or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

Appeals regarding any denial of coverage based on a service being Experimental or Investigational can be submitted to Member Services at 1145 Broadway, Suite 300, Tacoma, WA 98402.

**Extended Care Facility** means an institution, or a distinct part of an institution, that:

1. Is licensed as a Hospital, Extended Care Facility, or Rehabilitation Facility operating pursuant to state law;
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a Physician and the direct supervision of a registered nurse;
3. Maintains a daily record on each patient;
4. Has an effective Utilization Review plan;
5. Provides each patient with a planned program of observation prescribed by a Physician; and
6. Provides each patient with active treatment of an illness or injury, in accordance with existing Generally Accepted Standards of Medical Practice for that condition.

Extended Care Facility does not include a Facility primarily for rest, the aged, treatment of Substance Use Disorder, Custodial Care, nursing care, or for care of Mental Disorders or the mentally incompetent.

**External Review** is review of a health plan decision to deny coverage or payment for a service by a third-party Independent Review Organization (IRO) not related to the plan. External Review by an IRO can be requested after we deny an internal Appeal, and in urgent situations can be requested even if the internal Appeals process isn't yet completed. External Review is available whenever we make an Adverse Benefit Determination (see definition above). The IRO performing the review will either uphold our decision or overturn all or some of the decision. We must accept the IRO's decision as binding unless other remedies are available under state or federal law.

**Facility** means an institution categorized as a Hospital, an outpatient clinic, Hospice, an Extended Care Facility, an Urgent Care Center, an Ambulatory Surgical Center, a skilled nursing Facility, a Residential Treatment Facility, an Inpatient Facility or a Federally Qualified Health Center.

**Facility Fee** means a charge incurred to the Member for Covered Services rendered by a Network Provider in a Facility.

**Formulary** or **Preferred Drug List** means our list of covered drugs. It is available on our website at Ambetter.CoordinatedCareHealth.com or by calling our Member Services department.

**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 healthcare service, supply, or drug is Medically Necessary and is a Covered Service under the Contract. The decision to apply Physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by us.

**Generic Drugs**, also known as therapeutic equivalent medications, means Prescription Drugs/ medication that contain the same active ingredient(s), have the same dosage form (e.g., they are both tablets), have the same route of administration (e.g., they are both taken by mouth), and are identical in strength. These drugs may differ in shape, look (markings on the tablets or capsules), and inactive ingredients (such as color, flavor, and preservatives). Medications classified as therapeutic equivalents can be substituted for each other with the full expectation that both medications will produce the same effect and have the same level of safety.

**Grievance** means a written or oral Complaint submitted by or on behalf of a Covered Person regarding service delivery issues other than denial of payment for medical services or non-provision of medical services, including:

1. Dissatisfaction with medical care;
2. Waiting time for medical services;
3. Provider or staff attitude or demeanor; or
4. Dissatisfaction with service provided by us.

**Habilitation** or **Habilitation Services** means healthcare services for people with disabilities or developmental delays 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 in a variety of Inpatient or outpatient settings. Please see the Covered Services section for more details.

**Home Health Aide Services** means those services provided by a Home Health aide employed by a Home Healthcare Agency and supervised by a registered nurse, which are directed toward the personal care of a Member.

**Home Healthcare** or **Home Health** means care or treatment of an illness or injury at the Member's home that is:

1. Provided by a Home Healthcare Agency; and
2. Prescribed and supervised by a Physician.

**Home Healthcare Agency** or **Home Health Agency** means a public or private organization, or one of its subdivisions, that:

1. Operates pursuant to law as a Home Healthcare Agency;

2. Is regularly engaged in providing Home Healthcare under the regular supervision of a registered nurse;
3. Maintains a daily medical record on each patient; and
4. Provides each patient with a planned program of observation and treatment by a Physician, in accordance with existing Generally Accepted Standards of Medical Practice for the injury or illness requiring the Home Healthcare.

An agency that is approved to provide Home Healthcare to those receiving Medicare benefits will be deemed to be a Home Healthcare Agency.

**Hospice** refers to services designed for and provided to Members who are not expected to live for more than 6 months. Their purpose is to minimize patient discomfort and address the special physical, psychological, and social needs of a Terminally Ill Member and their Immediate Family. A Member may be transferred to a Hospice Program, licensed by the state, if necessary as determined by a Network Provider.

**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 from the emergency room in a short term observation status, a Member will not be considered in a Hospital for purposes of this Contract.

**Hospital Based Outpatient Clinic** means a clinic or office that provides Outpatient Services that are clinically integrated into a Hospital. The clinics are typically located within a Hospital campus. These Providers may charge a Facility Fee in addition to any charges for Covered Services. Facility Fees, as well as professional fees, are subject to applicable Cost Sharing.

**Hospital Based Provider** means a Provider who provides services chiefly within a Hospital, for example, anesthesiologists, emergency department Physicians, pathologies and radiologists. Please see additional information in the Access to Care section.

**Immediate Family** means the parents, Spouse, Eligible Child (by blood, adoption, marriage or state registered domestic partnership), or siblings of any Member.

**Independent Review Organization (IRO)** is an independent Physician review organization which acts as the decision-maker when External Review of a decision or Internal Appeal outcome is requested. A given IRO is assigned to us via state regulatory requirements, and acts as an independent contractor. The IRO is an impartial reviewer and we have no control over its decision.

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

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

**Intensive Day Rehabilitation** means two or more different types of therapy provided by one or more Rehabilitation Licensed Practitioners and performed for three or more hours per day, five to seven days per week.

**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 maximum amount a Member is required to pay in the form of Cost Sharing for covered benefits in a plan year, after which we will cover the entirety of the Allowed Amount for covered benefits and services received under this Contract. A Member's Deductible, Prescription Drug Deductible (if applicable), Copayment Amount, and Coinsurance all contribute towards the Maximum Out-of-Pocket Amount.

For family coverage, the family Maximum Out-of-Pocket Amount can be met with the combination of any Covered Persons' Eligible Service Expenses. A Covered Person's Maximum Out-of-Pocket will not exceed the individual Maximum Out-of-Pocket Amount.

If you are a covered Member in a family of two or more Members, you will satisfy your Maximum Out-of-Pocket when:

1. You satisfy your individual Maximum Out-of-Pocket; or
2. Your family satisfies the family Maximum Out-of-Pocket Amount for the calendar year.

If you satisfy your individual Maximum Out-of-Pocket, you will not pay any more Cost-Sharing for the remainder of the calendar year, but any other eligible Members in your family must continue to pay Cost Sharing until the family Maximum Out-of-Pocket is met for the calendar year.

The Adult Vision out-of-pocket maximum limits do not apply to the satisfaction of the out-of-pocket maximum 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 Member's medical condition can be expected, even though there may be fluctuations in levels of pain and function.

**Medical Practitioner** includes but is not limited to: a Physician, nurse anesthetist, physician assistant, physical therapist, certified nurse midwives, dentists (Doctor of Medical Dentistry or Doctor of Dental Surgery, or a denturist), chiropractors, podiatrists, nurses, social workers, optometrists, and psychologists. Services are permitted by every category of healthcare Provider licensed or certified to practice in accordance with Title 18 Revised Code of Washington and engaged in the delivery of services permitted by their scope of practice.

**Medically Necessary** means appropriate and clinically necessary healthcare services or supplies which are provided to a Member for the diagnosis, care or treatment of an illness or injury and which meet all of the standards set forth below:

1. Are not solely for the convenience of the Member, the Member's family or the Provider of the services or supplies;

2. Are the most appropriate level of service or supply which can be safely provided to the Member;
3. Are for the diagnosis or treatment of an actual or existing illness or injury unless being provided under the Preventive Care Benefits;
4. Are not for recreational, life-enhancing, relaxation or palliative therapy, except for treatment of terminal conditions;
5. Are appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the State of Washington, could not have been omitted without adversely affecting the Member's condition or the quality of health services rendered;
6. As to Inpatient care, could not have been provided in a Provider's office, the outpatient department of a Hospital or a non-residential Facility without affecting the Member's condition or quality of health services rendered;
7. Are not primarily for research and data accumulation; and
8. Are not Experimental or Investigational.

The fact that a Physician may prescribe, refer, or direct a service does not mean the service is Medically Necessary, Authorized or covered under this Contract. Medical necessity criteria for Covered Services will be furnished to a Member or Provider within 30 days of a request to do so.

Medical necessity determinations will be made in a timely manner by thorough review from Coordinated Care clinical staff. Determinations will be made utilizing guideline based care, appropriate utilization management policies, and by applying clinical judgment and experience. Medical policies are developed through periodic review of Generally Accepted Standards of Medical Practice and updated at least on an annual basis. Current medical policies are available on our website.

Charges incurred for treatment not Medically Necessary are not Eligible Service Expenses.

In the event that a Member may not agree with the medical necessity determination, a Member has the opportunity to Appeal the decision. Please refer to the "Grievance and Appeal Process" section of the Contract for information about filing an Appeal.

**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.

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

**Mental Disorder** means a behavioral, emotional or cognitive disorder that is listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or the most recent edition of the International Classification of Diseases.

**Mental Health Services** mean Medically Necessary outpatient and Inpatient services provided to treat Mental Disorders covered by the diagnostic categories listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, and the most recent edition of the International Classification of Diseases.

**Necessary Medical Supplies** mean medical supplies that are:

1. Necessary to the care or treatment of an injury or illness;
2. Not reusable or Durable Medical Equipment; and
3. Not able to be used by others.

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

**Network** means a group of Providers or Facilities (including, but not limited to Hospitals, Inpatient mental healthcare facilities, medical clinics, behavioral health clinics, acupuncturists, chiropractors, massage therapists, nurse practitioners, addiction medicine practitioners, etc.) who have contracts with us, or our contractor or subcontractor, and have agreed to provide healthcare services to our Members for an agreed upon fee. Members will receive most if not all of their healthcare services by accessing the Network. Ambetter from Coordinated Care's Network name is CCCWA Exchange.

**Network Eligible Service(s)** means Covered Service(s) that are provided by a Network Provider, or a service that has been Authorized at a Network Facility. Network Eligible Service(s) includes benefits for Emergency Services even if provided by a Non-Network Provider.

**Network Provider**, sometimes referred to as an "in-network Provider," means a Medical Practitioner or Facility who has contracted with us, or our contractor or subcontractor, to provide healthcare services to our Members and be reimbursed by us at the contracted rate as payment in full for the health care services, including applicable Cost Sharing obligations. These Providers will be identified in the most current list for the Network.

**Non-Network Provider**, sometimes referred to as an "out-of-network Provider," means a Medical Practitioner or Facility who is *not* contracted with us or our contractor or subcontractor. Services received from a Non-Network Provider or Facility are *not* covered, except for:

1. Emergency Services, as described in the Covered Services section of this Contract;
2. Non-emergency healthcare services received at an in-network Hospital or an in-network ambulatory surgical Facility, as described in the Access to Care section of this Contract; or
3. Situations otherwise specifically described in this Contract.

**Originating Site** means the physical location of a patient receiving healthcare services through Telemedicine.

**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 for therapeutic support, protection, restoration or function of an impaired body part for treatment of an illness or injury.

**Out-of-Pocket Expenses** mean those Cost Sharing amounts paid by a Member for Covered Services that are applied to the Maximum Out-of-Pocket Amount.

**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 us. These Facilities may include a non-hospital site providing diagnostic and therapy services, Surgery, Rehabilitation or other Provider Facility as determined by us. Professional charges only include services billed by a Provider.

**Pain Management Program** means a program using interdisciplinary teams providing coordinated, goal-oriented services to a Member who has chronic pain that significantly interferes with physical, psychosocial, and vocational functioning, for the purpose of reducing pain, improving function, and decreasing dependence on the healthcare 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 their licensed authority in treating a bodily injury or sickness and is required to be covered by state law. A Physician does

not include someone who is related to a Member by blood, marriage or adoption or who is normally a member of the Member's household.

**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." They are drugs that have been approved by the Food and Drug Administration (FDA) and which can, under federal or state law, be dispensed only with a prescription.

**Prescription Drug Deductible Amount** means the amount of covered expenses, shown in the Schedule of Benefits, if applicable, that must actually be paid during any calendar year before any Prescription Drug benefits are payable.

**Preventive Care Benefits** means Covered Services and supplies as defined by the United States Preventive Services Task Force (USPSTF) for evidence-based items or services that have a rating of A or B in effect. A listing of these services can be found on the USPSTF website at the following web address: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. Other federal agencies who define Preventive Care Benefits include the Health Resources and Services Administration (HRSA) and Advisory Committee on Immunization Practices (ACIP). These services are covered at no charge to you; however, a Cost Share for an office visit may apply if other Covered Services and supplies are provided during your visit.

**Primary Care Provider** or **PCP** means a Provider or Medical Practitioner who gives or directs healthcare services for the Member. Primary Care Providers include but are not limited to family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), Physician Assistants (PA), pediatricians, obstetricians and/or gynecologists (OB/GYN) and internists or any other practice allowed by the plan. A PCP supervises, directs and gives initial care and basic medical services to the Member and is in charge of the Member's ongoing care. Hospital based Primary Care Providers (those practicing on a Hospital campus or co-located within a Hospital) may charge a Facility Fee in addition to any charges for Covered Services. Facility Fees are payable by you and will be applied to your Deductible.

**Prior Authorization** is a process of obtaining Ambetter's Authorization for certain services before a Member receives them. Prior Authorization is our approval that a requested healthcare service, treatment plan, Prescription Drug or Durable Medical Equipment is Medically Necessary. Prior Authorization is not a promise that Ambetter will cover the cost of the service. Please refer to the Prior Authorization section of this Contract for further information.

**Prosthetic Device** means a Medically Necessary device used to replace, correct or support a missing portion of the body, to prevent or correct a physical deformity or malfunction, or to support a weak or deformed portion of the body.

**Provider** (see **Network Provider** and **Non-Network Provider** definitions).

**Qualified Health Plan** or **QHP** means a health plan that has in effect a certification granted by the Washington Health Benefits Exchange and has been approved by the Washington State Office of the Insurance Commissioner.

**Qualified Individual** means, with respect to the Exchange, an individual who has been determined eligible to enroll through the Exchange in a Qualified Health Plan in the individual market.

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

**Rehabilitation** means the Medically Necessary services that help a person keep, restore or improve skills and function for daily living that have been lost or impaired because a person was sick, hurt or disabled. This type of care 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 wards that:

1. Is licensed 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, massage 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 (including massage therapy), occupational therapy, speech therapy, aural therapy, or respiratory therapy to regain function lost or diminished as a result of injury or illness.

**Rescission** of a Contract means a determination by us 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 a skilled nursing Facility.

**Respite Care** means Home Healthcare services provided temporarily to a Member in order to provide relief to the Member's Immediate Family or other caregiver.

**Schedule of Benefits** means a summary of the Deductible, Copayment, Coinsurance, Maximum Out-of-Pocket and other limits that apply when you receive Covered Services and supplies.

**Service Area** means a geographical area, made up of counties, where we have been authorized by the State of Washington to sell and market our health plans. Those counties are: Adams, Benton, Chelan, Columbia, Douglas, Franklin, Grant, Jefferson, King, Kitsap, Kittitas, Lewis, Lincoln, Pierce, Snohomish, Spokane, Stevens,

Thurston, Walla Walla, and Yakima. You can receive precise Service Area boundaries from our website or our Member Services department.

**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 Provider** 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 or state registered domestic partner as required by Washington law.

**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 Member is confined as an Inpatient in a Hospital, Rehabilitation Facility, or Extended Care Facility.

**Substance Use Disorder** means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under the Uniform Controlled Substance Act and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or the user's social or economic function is substantially disrupted. Covered Substance Use Disorders are those listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or the most recent edition of the International Classification of Diseases. See also, Chemical Dependency.

**Surgery** means:

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

**Surgical** or **Ancillary Services** means Surgery, anesthesiology, pathology, radiology, laboratory, or hospitalist services.

**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.

**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.

**Telehealth Services** is the provision of health care services using telecommunications technology.

**Telemedicine** means the delivery of healthcare services through the use of interactive audio and video technology, permitting real-time communication between the patient at the Originating Site and the Provider, for the purpose of diagnosis, consultation, or treatment. Telemedicine does not include audio-only telephone, fax, or email.

**Terminal Illness Counseling** means counseling of the Immediate Family of a Terminally Ill person for the purpose of teaching the Immediate Family to care for and adjust to the illness and impending death of the Terminally Ill person.

**Terminally Ill** means a Physician has given a prognosis that a Member has six months or less to live.

**Tobacco Use** 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 the last six months immediately preceding the date the application for this Contract was completed by the Member, including all tobacco products but excluding religious and ceremonial uses of tobacco.

**Transcranial Magnetic Stimulation (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.

**Urgent Care** is care for a condition that is not an emergency; but is an unforeseen medical illness, injury, or condition that requires immediate care when your Primary Care Provider is unavailable or inaccessible. Your benefits for a no cost preventive care exam may not be used at an Urgent Care Center.

**Urgent Care Center** is a Facility, not including a Hospital emergency room or a Physician's office, that provides treatment or services that are required:

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

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

**Women's Healthcare Services** are defined to include, but need not be limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as Medically Necessary, and Medically Necessary follow-up visits for these services. General examinations, preventive care, and Medically Necessary follow-up care are limited to services related to maternity, reproductive health services, gynecological care, or other health services that are particular to women, such as breast examinations. Women's Healthcare Services also include any appropriate healthcare service for other health problems, discovered and treated during the course of a visit to a women's healthcare practitioner for a Women's Healthcare Service, which is within the practitioner's scope of practice. For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health, and Preventive Care Benefits include, contraceptive services, testing and treatment for sexually transmitted diseases, Pregnancy termination, breast-feeding, and Complications of Pregnancy.

# MEMBER AND DEPENDENT COVERAGE

**Member Eligibility**
To be eligible for Covered Services, you must be enrolled and covered under the Contract. To be eligible to enroll as a Member you must meet the eligibility criteria listed below or as otherwise required by the Washington Health Benefit Exchange, such as:

1. The primary Member must currently live in the Service Area;
2. Be a Qualified Individual eligible for coverage through the Exchange;
3. Not be eligible for coverage under an employer group health or medical contract; and
4. Not be eligible for Medicare on the date coverage begins.

**Member and Dependent Member Effective Date**
Eligible persons may apply for coverage by submitting a completed application to the Washington Health Benefit Exchange. Eligible Members and Dependent Members included on the application will not be enrolled or premium will not be accepted until the completed application has been approved.

Your Dependent Members become eligible for coverage under this Contract on:

1. The date you became covered under this Contract; 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 the subscriber for the purposes of adoption or the subscriber assumes total or partial financial support of the child.

**Coverage for a Newborn Child**
An Eligible Child born to you or a Dependent Member will be covered from the time of birth for up to 21 days following its birth even if there are separate Hospital admissions. The newborn child will be covered from the time of birth until the 21st day after birth for Medically Necessary Covered Services. Each type of Covered Service incurred by the newborn child will be subject to the Cost Sharing amount listed in the Schedule of Benefits.

Additional premium payment may be required to continue coverage beyond the 21st day after the date of birth. The required premium will be calculated from the child's date of birth. If notice of the newborn is given to us by the Exchange within the 21 days from birth, an additional premium for coverage of the newborn child will be charged for not less than 21 days after the birth of the child. If notice is not given within the 21 days from birth, we will charge an additional premium from the date of birth. If notice is given by the Exchange within 60 days of the birth of the child, the Contract may not deny coverage of the child due to failure to notify us of the birth of the child or to pre-enroll the child. Coverage of the child will terminate 21 days after its birth, unless we have received notice from the entity in which you have enrolled (either the Exchange or us).

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

An Eligible Child legally placed for adoption with you or your Spouse will be covered from the date of Placement until the 31st day after Placement, unless the Placement is disrupted prior to legal adoption and the child is removed from you or your Spouse's custody.

The child will be covered for loss due to injury and illness, including Medically Necessary care and treatment of conditions existing prior to the date of Placement.

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

**Adding Dependent Members**
Dependents should be added or removed through the Washington Health Benefit Exchange.

**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.

If there is no prior coverage or no continuation of Inpatient coverage after the Effective Date, your Ambetter coverage will apply for covered benefits related to the Inpatient coverage after your Effective Date. Ambetter coverage requires you notify Ambetter within 2 days of your Effective Date so we can review and Authorize Medically Necessary services. If services are at a non-contracted Hospital, Claims will be paid at the Allowed Amount and you may be billed for any balance of costs above the Ambetter allowable.

**Commencement of Benefits for Persons Hospitalized on Effective Date**
Members who are admitted to an Inpatient Facility prior to their enrollment under the Contract will receive covered benefits beginning on their Effective Date as set forth above. If a Member is hospitalized in a non-network Facility, we reserve the right to require transfer of the Member to a Network Facility. The Member will be transferred when a Network Provider, in consultation with the Attending Physician, determines that the Member is Medically Stable to do so. If the Member refuses to transfer to a Network Facility, all further costs incurred during the hospitalization are the responsibility of the Member.

# ONGOING ELIGIBILITY

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

1. The date that a Member has failed to pay premiums or contributions in accordance with the terms of this Contract or the date that we have not received timely premium payments in accordance with the terms of this Contract;
2. The date the Member has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact;
3. The date we decline to renew this Contract, as stated in the Discontinuance provision;
4. The date of a Member's death;
5. The date of termination that the Exchange provides us upon your request of cancellation to the Exchange, or if you enrolled directly with us, the date we receive a request from you to terminate this Contract, or any later date stated in your request;
6. The Member's coverage is terminated by the Exchange; or
7. The primary Member resides outside the Service Area or moves permanently outside the Service Area of this plan.

**For Dependent Members**
A Dependent Member will continue to be a Member until the end of the premium period in which the Member ceases to be your Dependent Member. For Eligible Children, coverage will terminate the thirty-first of December the year in which the dependent turns 26 years of age. A Member will not cease to be a dependent Eligible Child solely as a result of the 26th birthday if the Eligible Child is and continues to be both:

1. Incapable of self-sustaining employment by reason of developmental disability or physical handicap; and
2. Chiefly dependent on the primary Member for support and maintenance.

Enrollment for such a dependent may be continued for the duration of such incapacity and dependence, provided enrollment does not terminate for any other reason. Proof of incapacity and dependence, such as a statement from the Member's Provider, and proof of financial dependency must be furnished to us upon request, but not more frequently than annually after the two (2) year period following the dependent's attainment of the limiting age. For additional information on continuing an Eligible Child's coverage beyond their 26th birthday please contact the Exchange.

If you have material modifications (examples include a change in life event such as marriage, death or other change in family status) or questions related to your health insurance coverage, please contact the Washington Health Benefit Exchange. If you enrolled through Ambetter, please contact 1-877-687-1197 (TTY/ TDD 1-877-941-9238).

**Open Enrollment**
There will be an open enrollment period for coverage on the Exchange. The open enrollment period begins November 1, 2019 and extends through December 15, 2019. Qualified Individuals who enroll prior to December 15, 2019 will have an Effective Date of coverage on January 1, 2020.

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

1. A Qualified Individual or dependent loses minimum essential coverage, non-calendar year group or individual health insurance coverage, pregnancy-related coverage, access to healthcare services through coverage provided to a pregnant enrollee's unborn child, or medically needed coverage;

2. A Qualified Individual loses employer sponsored coverage for any reason, including but not limited to death of the employee, termination of employment or reduction in the number of hours of employment, except for misrepresentation of a material fact affecting coverage or for fraud related to the discontinued health coverage;
3. A Qualified Individual experiences the loss of eligibility for Medicaid or a public program providing health benefits;
4. A Qualified Individual gains a dependent or becomes a dependent through marriage, domestic partnership, birth, adoption, foster children, placement for adoption, placement in foster care, or a child support order or other court order;
    a. In the case of marriage, at least one Spouse must demonstrate having minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage.
5. An individual who is no longer incarcerated or whose incarceration is pending the disposition of charges;
6. A Qualified Individual loses coverage as the result of legal separation, dissolution of marriage or termination of a domestic partnership;
7. A Qualified Individual experiences a permanent change in Residence, work, or living situation, whether or not within the choice of the individual, where the health plan under which they were covered does not provide coverage in that person's new Service Area or results in new eligibility for previously unavailable Qualified Health Plans;
8. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the Qualified Individual;
9. Coverage is discontinued in a Qualified Health Plan by the Exchange pursuant to 45 C.F.R. 155.430 and the three month grace period for continuation of coverage has expired;
10. Exhaustion of COBRA coverage due to failure of the employer to remit premium;
11. Loss of COBRA coverage where the Qualified Individual has exceeded the lifetime limit in the plan and no other COBRA coverage is available;
12. A Qualified Individual discontinues coverage under a health plan offered pursuant to the Washington State Health Insurance Coverage Access Act;
13. A Qualified Individual loses coverage as a dependent on a group plan due to age;
14. An Indian, as defined by section 4 of the Indian Healthcare Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month, without requiring an additional special enrollment triggering event;
15. A Qualified Individual loses prior coverage due to errors by the Exchange staff or the U.S. Department of Health and Human Services;
16. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
17. An enrollee demonstrates to the Exchange that the Qualified Health Plan in which the enrollee is enrolled violated a material provision of its Contract in relation to the enrollee's decision to purchase the Qualified Health Plan based on plan benefits, Service Area or premium;
18. An individual is determined newly eligible or newly ineligible for Advance Premium Tax Credit or has a change in eligibility for Cost-Sharing Reductions, or the individual's dependent becomes newly eligible;
19. The individual or their dependent who is currently enrolled in employer sponsored coverage is determined to be newly eligible for Advance Premium Tax Credits;
20. A Qualified Individual or dependent is a victim of domestic abuse or spousal abandonment and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;

21. A Qualified Individual or dependent is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 days after the qualifying event; or
22. At the option of the Exchange, a Qualified Individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a Qualified Health Plan through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence.

If the enrollee eligible for the special enrollment period had prior coverage, they will be offered the benefit packages available to individuals who enrolled during the open enrollment period within the same metal tier or level at which the enrollee had previously. Any difference in benefits or Cost-Sharing requirements for different individuals constitutes a different benefit package. An eligible enrollee will not be required to pay more for coverage than a similarly situated individual who enrolls during open enrollment. An enrollee who was enrolled in a catastrophic plan as defined in RCW 48.43.005(8) may be limited to the plans available during open enrollment at either the bronze or silver level. An enrollee whose eligibility is based on their status as a dependent may be limited to the same metal tier for the plan on which the primary subscriber is enrolled. The Exchange may require reasonable proof or documentation that an individual seeking special enrollment has experienced a qualifying event.

This section should not be interpreted to limit the Exchange's rights to automatically enroll Qualified Individuals based on good cause or exceptional circumstances as defined by the Exchange or as required by the U.S. Department of Health and Human Services.

Qualified Individuals who enroll and pay their first month's premium between the first and fifteenth day of the month will have a coverage Effective Date of the first day of the following month. Qualified Individuals who enroll between the fifteenth and last day of the month will have a coverage Effective Date of the first day of the second following month. In the case of birth, adoption, foster care, placement for adoption or placement for foster care, the coverage is effective on the date of birth, adoption, foster care, placement for adoption or placement for foster care, but advance payments of the premium tax credit and Cost-Sharing Reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, foster care, placement for adoption or placement for foster care occurs on the first day of the month. In the case of marriage or the beginning of a domestic partnership, or in the case where the Qualified Individual loses minimum essential coverage, the Effective Date is the first day of the following month.

American Indians/Alaskan Natives eligible for services through an Indian healthcare Provider may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month. Please contact the Exchange for more information.

# PREMIUMS

**Premium Payment**
Each monthly premium is to be paid to Coordinated Care on or before 4:59 p.m. PST on the last day of the month for coverage effective during the subsequent month to ensure there is no disruption of services.

**Grace Period**
When a Member is receiving a premium subsidy:

> After the first premium, also known as a "binder payment," is paid, a grace period of three (3) months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if Advance Premium Tax Credits are received.
>
> We will continue to pay all appropriate Claims for Covered Services rendered to the Member during the first month of the grace period, and will pend the processing of Claims for Covered Services rendered to the Member in the second and third month of the grace period. We will notify the Exchange of the non-payment of premiums, and notify the Member, as well as Providers of the possibility of denied Claims when the Member is in the second and third month of the grace period. We will continue to collect Advance Premium Tax Credits on behalf of the Member from the Department of the Treasury, and will return the Advance Premium Tax Credits on behalf of the Member for the second and third month of the grace period if the Member exhausts their grace period as described above.

When a Member is not receiving a premium subsidy:

> There is a one (1) month grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force; however, Claims will remain pending for Covered Services rendered to the Member during the grace period. We will notify the Exchange, as necessary, of the non-payment of premiums, the Member, as well as Providers of the possibility of denied Claims when the Member is in the grace period.

**Third Party Payment of Premiums or Cost Sharing**
Ambetter requires each Contract holder to pay their premiums and this is communicated on your monthly billing statements. Ambetter payment policies were developed based on guidance from the Centers for Medicare and Medicaid Services (CMS) recommendations against accepting third party premiums. Consistent with CMS guidance, the following are the ONLY acceptable third parties who may pay Ambetter premiums on your behalf:

1. Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
2. Indian tribes, tribal organizations or urban Indian organizations;
3. State and Federal Government programs;
4. Family members;
5. Private, not-for-profit foundations which have no incentive for financial gain, no financial relationship, or affiliation with Providers of Covered Services and supplies on behalf of Members, where eligibility is determined based on defined criteria without regard to health status and where payments are made in advance for a coverage period from the Effective Date of eligibility through the remainder of the calendar year; or
6. Approved premium sponsorship programs.

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

Similarly, if we determine payment was made for Deductibles or Cost Sharing by a third party, such as a drug manufacturer paying for all or part of a medication, that shall be considered a third party premium payment that may not be counted towards your Deductible or Maximum Out-of-Pocket costs.

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

**Misstatement of Tobacco Use**
The answer to the Tobacco Use question is material in determining your premium rating. If a Member's Tobacco Use has been misstated on the Member's application for coverage under this Contract, we have the right to change the premium rating for the Contract, and apply the change back to the original Effective Date.

**Right to Change Premium**
We have the right to change premiums after filing and receiving approval by the state of Washington. We will change the rate table used for this Contract form annually. Each premium will be based on the rate table in effect on that premium's due date. Factors used in determining your premium rates may include: geographic area, family size, age, tenure discounts and wellness activities. Additionally, the premium may be changed more frequently to reflect changes to: family composition, the health benefit plan requested by you, or government requirements affecting the health benefit plan.

If we change your premium, we will provide 30 day notice delivered to you at your last address as shown in our records. We will make no change in your premium solely because of Claims made under this Contract or a change in a Member's health. While this Contract is in force, we will not restrict coverage already in force.

# COST SHARING FEATURES

**Cost Sharing Features**
We will pay benefits for Covered Services as described in the Schedule of Benefits and the Covered Services sections of this Contract. All benefits we pay will be subject to all conditions, limitations, and Cost Sharing features of this Contract. Cost Sharing means that you participate or share in the cost of your healthcare services by paying Deductible Amounts, Copayments and Coinsurance for some Covered Services. For example, you may need to pay a Copayment or Coinsurance amount when you visit your Physician or are admitted into the Hospital. The Copayment or Coinsurance required for each type of service as well as your Deductible is listed in your Schedule of Benefits.

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 a fixed amount typically due (and payable to the Provider or Facility) 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 services not covered by your benefits. Copayments do not count or apply toward the Deductible Amount, but do apply toward your Maximum Out-of-Pocket Amount.

**Coinsurance Percentage**
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.

**Deductible**
Some Covered Services are subject to an annual Deductible. The Deductible means the amount of Covered Services, including Prescription Drugs, that must be paid by the Member(s) before any benefits are payable.

There is an individual annual Deductible for each Member and a maximum aggregate annual Deductible for family coverage. The family Deductible Amount is two times the individual Deductible Amount. For family coverage, once a covered Member has met the individual Deductible, the remainder of the family Deductible can be met with the combination of any one or more covered Members' Eligible Service Expenses. Coinsurance amounts and Copayments do not apply toward satisfying the Deductible.

**Maximum Out-of-Pocket**
You must pay any required Deductible, 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 Copayments, Coinsurance and other limitations.**
The amount provided or payable will be subject to:

1. Any specific benefit limits stated in the Contract;
2. A determination of Eligible Service Expenses; and
3. Any reduction for expenses incurred at a Non-Network Provider.

The applicable Deductible Amount(s), Coinsurance, and Copayment Amounts are shown on the Schedule of Benefits.

# ACCESS TO CARE

**Primary Care Provider**
To obtain Covered Services, we recommend you designate a Primary Care Provider (PCP) for each Member. You may select any PCP who is accepting new patients. If you do not select a PCP for each Member, one will be assigned. You may get a list of PCPs within our Network, CCCWA Exchange, at our website or by contacting our Member Services department. Members may choose to have any Physician or Medical Practitioner listed under "Women's Healthcare Direct Access Providers" in this section as their PCP.

**Your PCP is responsible for coordinating all Covered Services with other Network Providers. The requirements for Prior Authorization are contained in this Contract. Services may not be covered if the Prior Authorization requirements are not met. Please refer to the Prior Authorization section of this Contract and your Schedule of Benefits for additional information.**

Members do not need a referral from their PCP for mental or behavioral health services or for obstetrical or gynecological treatment and may seek care directly from a Provider as described in the "Women's Healthcare Direct Access Providers" provision in this section.

You may change your PCP at any time by submitting a written request, online at our website, or by contacting our office at the number shown on your identification card. We can make your choice of PCP effective on the next business day, if the selected Physician caseload permits. The change will be effective no later than the beginning of the month following your change request.

We will notify you if your PCP leaves our Network. You will be provided access to the Provider for at least sixty (60) days from that notice. During those sixty (60) days, we will offer you a selection of new PCPs from which to choose.

**Specialists**
Unless otherwise indicated in this Contract, Prior Authorization may be required for services received from a Specialist Provider. Prior Authorization is not required for an initial evaluation and management visit and up to six (6) consecutive treatment visits with a contracted Provider in a new episode of care of chiropractic, physical therapy, occupational therapy, East Asian medicine, massage therapy, or speech and hearing therapies that meet the standards of medical necessity. If you have a chronic medical condition, you may request a standing Authorization for specialist services. Some Specialists may act as a PCP for Members with a severe chronic medical condition. This is permitted if the Specialist provides all basic healthcare services and they are contracted with us as a PCP. Contact Member Services to find out which Providers serve in both roles.

**Second Opinions**
Upon request, Members may access a second opinion regarding a medical diagnosis or treatment plan from a Network Provider. Second opinions requested from Non-Network Providers must be Authorized in advance. Coverage is determined by the Member's Contract; therefore, coverage for the second opinion does not imply that the services or treatments recommended will be covered.

**Emergency and Urgent Care**
Emergency Care
Emergency Services do not need Prior Authorization. Emergency care is available at Network Hospitals and Facilities. If you cannot get to a Network Facility, you may obtain Emergency Services from the nearest Hospital regardless of if they are a Network Provider (see the Hospital Based Providers provision below). Members or persons assuming responsibility for a Member must notify us within twenty-four (24) hours of admission to a non-network Facility, or as soon thereafter as medically possible. If a Member is admitted to a Network Facility directly from the emergency room the emergency Cost Share is waived. However, coverage will be subject to any Inpatient Cost Sharing.

Urgent Care
In the Service Area, Urgent Care is covered at Network Hospitals and Urgent Care Centers, or Network Providers' offices. Your Preventive Care Benefits may not be used at an Urgent Care Center.

Outside our Service Area, if Authorized, Urgent Care is covered at any medical Facility. Members are responsible for Cost Share amounts and may be responsible for amounts above the Eligible Service Expense.

**Non-Network Providers at Hospitals or Ambulatory Surgical Facilities**
A Non-Network Provider cannot Balance Bill you for services provided at a Network Hospital, or for Surgical or Ancillary Services provided at a Network ambulatory surgical Facility. If you are treated by a Non-Network Provider at a Network Hospital or ambulatory surgical Facility, your Cost Sharing responsibility for the Non-Network services will be no greater than if the Provider had been in our Network.

**Transfer to Network Facility**
If a Member is hospitalized in a non-network Facility, we reserve the right to require transfer of the Member to a Network Facility. The Member will be transferred when a Network Provider, in consultation with the Attending Physician, determines that the Member is Medically Stable for transfer. If the Member refuses to transfer to a Network Facility, all further costs incurred during the hospitalization are the responsibility of the Member.

**Women's Healthcare Direct Access Providers**
Members may see a Network Provider, general and family practitioner, physician assistant, gynecologist, certified nurse midwife, licensed midwife, doctor of osteopathy, pediatrician, obstetrician or advanced registered nurse practitioner who is contracted by us to provide Women's Healthcare Services directly, without a referral, for Medically Necessary maternity care, covered reproductive health services, preventive care (well care) and general examinations, gynecological care and follow-up visits for the above services. Women's Healthcare Services are covered as if the Member's Primary Care Provider had been consulted, subject to any applicable Cost Sharing, as set forth in the Schedule of Benefits.

**Telemedicine and Telehealth**
You may receive services from your Provider from your home or other location away from your Provider's office. Telemedicine covers Covered Services received using audio and video technology. In addition to services by your Provider, Telehealth Services are available through Teladoc, a Network of Providers available by telephone or audio and video technology that you can access nationwide.

**Service Area**
Coordinated Care operates in a limited Service Area. Most Providers in Coordinated Care's Provider Network in Washington (CCCWA Exchange) are located in the Service Area, however some may be in the Network and located in the adjacent county or state. These Providers are shown on the "Find a Provider" tool at Ambetter.CoordinatedCareHealth.com.

If you move from one county to another within the Service Area your premium may change. Please refer to the Premium section of this Contract for more information. If you move from a county in the Service Area to a county not in the Service Area, you will no longer be eligible for coverage under this Contract and may be eligible for enrollment into another Qualified Health Plan during a Special Enrollment Period.

**Providers Outside of Washington**
Emergency Services
When you receive Emergency Services and supplies outside of Washington State, Covered Services and supplies for Emergency Medical Conditions can be furnished by any Emergency Services Provider that meets the following requirements:

1. State-licensed or state-certified;

2. Performing services within the scope of their license or certification.

If, by chance, you get Emergency Services from a Provider that has a contract with Ambetter outside of Washington State, your Out-of-Pocket Expenses may be reduced. This is because those Providers have agreed to accept Ambetter's Allowed Amount for Covered Services as payment in full. When you receive covered emergency care from one of these contracted Providers, you are responsible only for any Cost Sharing (Deductible, Copays, or Coinsurance) required by this plan.

Non-Emergency Services

If you are traveling outside of the Washington Service Area you may be able to access Providers in another state if there is an Ambetter plan located in that state. You can locate Ambetter Providers outside of Washington by searching the relevant state in our Provider directory at ProviderSearch.AmbetterHealth.com. Not all states have Ambetter plans. If you receive care from an Ambetter Provider outside of the Service Area, you may be required to receive a Prior Authorization for non-emergency services. Contact Member Services at the phone number on your ID card for further information.

# COVERED SERVICES

You are covered for the Medically Necessary Covered Services and supplies provided by Network Providers as described in this Contract and the Schedule of Benefits. Covered Services must be Medically Necessary and not Experimental or Investigational, except as otherwise described in this Contract. You will be required to pay any applicable Copayment, Coinsurance and Deductible Amounts. Copayment Amounts must be paid to your Network Provider at the time you receive services.

Some services and supplies require Prior Authorization in order to be Covered Services. Please refer to the Prior Authorization section in this Contract or contact Member Services for questions regarding Prior Authorization.

All Covered Services and supplies are subject to the conditions, terms, provisions, limitations and exclusions described in this Contract and your Schedule of Benefits. Benefit limitations may also apply to some Covered Services that fall under more than one Covered Service category. Please review all limits carefully. Ambetter from Coordinated Care will not pay benefits for any of the services, treatments, items or supplies that exceed benefit limits.

**Acupuncture**
Covered Services and supplies for acupuncture treatment are provided on an in-network outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits.

**Alternative Care – Home Healthcare or Hospice**
We cover alternative care as an alternative to hospitalization. Coverage shall be offered to Members who may be at home and would otherwise require hospitalization or institutional expenses. Coverage will include substitution of Home Healthcare, provided in lieu of hospitalization or other institutional care, furnished by in-network Home Health, Hospice and Home Healthcare Agencies. Substitution of less expensive or less intensive services shall be made only with the consent of the Member and upon the recommendation of the Member's Attending Physician or licensed Medical Practitioner that such services will adequately meet the Member's needs.

Home Healthcare and Hospice care coverage offered shall conform to the following standards, limitations, and restrictions:

1. Such expenses will include coverage for Durable Medical Equipment which permits the Member to stay at home, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day healthcare, Home Health, Hospice and home care, or similar alternative care arrangements which provide necessary care in less restrictive or less expensive environments.
2. Coverage will be limited to the maximum benefits which would be payable for Hospital or other institutional expenses under the Contract and will include all Cost Sharing payable by the Member under the Hospital or other institutional expense coverage of the Contract.
3. The coverage will require that Home Health Agencies and similar alternative care Providers have written treatment plans approved by the Member's Attending Physician or other licensed Medical Practitioner.

**Ambulance Service Benefits**
Covered Service and supply expenses will include ambulance services for local ground transportation and treatment provided as part of the ambulance service:

1. To the nearest Hospital that can provide services appropriate to the Member's illness or injury, in cases of emergency.
2. To the nearest neonatal special care unit for newborn infants for treatment of illnesses, injuries, congenital birth defects, or complications of premature birth that require that level of care.

3. Transportation between Hospitals or between a Hospital and skilled nursing or Rehabilitation Facility when Authorized by Ambetter from Coordinated Care.

Limitations: Benefits for air ambulance services are limited to:

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

Please note that non-emergency air ambulance services may require Prior Authorization.

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. Ambulance services provided for a Member's comfort or convenience.
3. Non-emergency transportation, excluding ambulances (for example, transport van, taxi).

**Ambulatory Patient Services**
Covered Service and supply expenses for ambulatory patient services will include Medically Necessary services delivered in settings other than a Hospital or Rehabilitation or Extended Care Facility, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat illness or injury. Such services include in-network:

1. Hospice and Home Healthcare, including skilled nursing care as an alternative to hospitalization;
2. Provider office visits and treatments, and associated supplies and services, including therapeutic injections and related supplies;
3. Urgent Care Center visits, including Provider services, Facility costs and supplies;
4. Ambulatory Surgery Center (see below provision);
5. Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures;
6. Oral Surgery related to trauma and injury, including services or appliances necessary for or resulting from medical treatment if the service is either emergency in nature or requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease; and
7. Physician contraceptive services and supplies including, but not limited to, vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.

**Ambulatory Surgical Center**
Outpatient Services and supplies provided at an in-network Ambulatory Surgery Center including:

1. Anesthesiology;
2. Surgical Services;
3. Surgical supplies; and
4. Facility costs (including services of staff Providers billed by the Hospital).

**Autism Spectrum Disorder Benefits**
Generally recognized services prescribed in relation to Autism Spectrum Disorder by an in-network 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:

1. Evaluation and assessment services;
2. Applied Behavioral Analysis;

3. Behavior training and behavior management;
4. Speech therapy;
5. Occupational therapy;
6. Physical therapy; or
7. Habilitation Services, limited to children ages 0 to 21 with a diagnosis of Autism Spectrum Disorder; or
8. Medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

**Chiropractic Care**
Covered Services and supplies include Medically Necessary Chiropractic Care to treat or diagnose neuromusculoskeletal disorders on an in-network outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. Covered Service and supply expenses are subject to all other terms and conditions of the Contract, including Deductible and Coinsurance Percentage provisions.

**Clinical Trials**
"Clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, funded or approved by:

1. One of the National Institutes of Health (NIH);
2. An NIH cooperative group or center which is a formal Network of Facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group including, but not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;
3. The federal Departments of Veterans Affairs or Defense;
4. A review board of an institution in this state with a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the NIH; or
5. A qualified research entity that meets the criteria for NIH Center Support Grant eligibility.

We will cover Medically Necessary routine costs for Members who participate in a clinical trial if:

1. The clinical trial is undertaken for the purpose of prevention, early detection or treatment of cancer or other life threatening illnesses or condition for which no standard or more effective standard treatment exists;
2. The clinical trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology;
3. The clinical trial is being provided in Washington State as part of a scientific study of a new therapy or intervention that is being conducted at an institution in Washington and is for the treatment, palliation or prevention of cancer or disease in humans with: specific goals; a rationale and back ground for the study; criteria for patient selection; specific direction for administering the therapy or intervention and for monitoring patients; a definition of quantitative measures for determining treatment response; methods for documenting and treating adverse reactions; and a reasonable expectation that the treatment will be at least as effective as standard cancer treatment or other life threatening illness treatment; and
4. The personnel providing the clinical trial or conducting the study (a) are providing the clinical trial or conducting the study within their scope of practice, experience and training and are capable of providing the clinical trial because of their experience, training and volume of patients treated to maintain their expertise; (b) agree to accept reimbursement as payment in full from us and that is not more than the level of reimbursement applicable to other similar services provided by the Network Providers within our Network; and (c ) agree to provide written notification to us when a patient enters or leaves a clinical trial.

Medication prescribed as part of a clinical trial which is not the subject of the trial, will be covered as other Prescription Drugs under the Contract.

Covered Services and supplies for clinical trials will not include:

1. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
2. Items and services provided solely to satisfy data collection and analysis needs;
3. Items and services that are not used in the direct clinical management of the Member; or
4. The Investigational item, device, or service itself.

"Life threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

“Routine costs" means items and services delivered to the Member that are consistent with and typically covered by the Contract for a Member who is not enrolled in a clinical trial. The Member will be responsible for any Cost Sharing amounts related to the use of Network services.

**Colorectal Screening**
Covered Services and supplies include colorectal screenings for determining the presence of precancerous or cancerous conditions and other health problems. Screenings are available in-network for adults over 50 or adults under 50 when at high risk for colorectal cancer and in accordance with the recommendations established by the United States Preventive Services task force. Please refer to the Preventive Care Benefits section. If a colorectal screening (including all related services like polyp biopsies and pathology tests) is not being done as a recommended preventive service, the Provider may bill the service as diagnostic rather than preventive, in which case it will be subject to the Cost Share of a diagnostic service, rather than the zero Cost Share of a preventive service. Colonoscopy services provide to Members with a history of polyps will be considered diagnostic services.

**Contraception**
All FDA-approved contraception methods (identified on www.fda.gov), including over-the-counter FDA-approved contraceptives, are approved for Members without Cost Sharing. Members have access to the methods available and outlined on our Drug Formulary or Preferred Drug List without Cost Share. Some contraception methods are available through a Member’s medical benefit, including the insertion and removal of the contraceptive device at no Cost Share to the Member. Emergency contraception is available to Members without a prescription and at no Cost Share to the Member. For further detail, please see the definition of Family Planning, below.

**Craniomandibular Joint (CMJ) and Temporomandibular Joint (TMJ) Dysfunction Conditions**
Covered Services and supplies include Medically Necessary services, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint. Prior Authorization may be required prior to receiving services or supplies. See the Schedule of Benefits for benefit levels or additional limits.

**Dental Services**
Covered Services and supplies are provided for general anesthesia services and related Facility charges in conjunction with any dental procedure performed at an in-network Hospital or Ambulatory Surgical Center if such anesthesia services and related Facility charges are Medically Necessary because the Member:

1. Is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or
2. Has a medical condition that the Member's Physician determines would place the person at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the Member's Physician.

**Diabetes Coverage**
Covered Services and supplies include Medically Necessary services and supplies used in the treatment of diabetes. Covered Services and supplies include, but are not limited to, insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, glucagon emergency kits, and out-patient self-management training and education, including medical nutrition therapy, as ordered by the in-network healthcare Provider. Prior Authorization may be required prior to receiving some services and supplies.

**Dialysis Services**
Medically Necessary acute and chronic dialysis services are covered benefits. Coverage for End Stage Renal Disease patients for whom Medicare is Primary, benefits will be payable subject to the Coordination of Benefits provision of this Contract. 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 Service and supply expenses include:

1. Services provided in an outpatient dialysis Facility or when services are provided in the home;
2. Processing and administration of blood or blood components;
3. Dialysis services provided in a Hospital;
4. Dialysis treatment of an acute or chronic kidney ailment, which may include the supportive use of an artificial kidney machine.

After you receive appropriate training at an in-network 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.

**Durable Medical Equipment (DME), Devices and Supplies**
The following are Covered Services and supplies when Medically Necessary and in-network:

Orthopedic Appliances: Orthopedic appliances, which are attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration or improvement of its function.

> Exclusions: orthopedic shoes that are not attached to an appliance; arch supports, including custom shoe modifications or inserts and their fittings, except for therapeutic shoes, modifications and shoe inserts for diabetic foot disease.

Ostomy Supplies: Ostomy supplies for the removal of bodily secretions or waste through an artificial opening. Quantities that are greater than CMS guidelines may require Prior Authorization by us.

Durable Medical Equipment: Durable Medical Equipment is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and used in the Member's home. Durable Medical Equipment includes: standard Hospital beds, standard non-motorized wheelchairs, wheelchair cushion, standard walkers, crutches, canes, glucose monitors, external insulin pumps, oxygen, and oxygen equipment. Some Durable Medical Equipment must receive Prior Authorization. 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.

Prosthetic Devices: Prosthetic Devices are items which replace all or part of an external body part, or function thereof.

When Authorized in advance, repair, adjustment or replacement of appliances and equipment is covered.

> Exclusions: take-home dressings and supplies following hospitalization; any other supplies, dressings, appliances, devices or services which are not specifically listed as covered above**;** replacement or repair of appliances, devices and supplies due to loss, breakage from willful damage, neglect or wrongful use, or due to personal preference.

**Emergency Services**
Covered Service and supply expenses for an Emergency Medical Condition include the following:

1. Emergency Services necessary to screen and stabilize a Member if a prudent layperson acting reasonably would have believed that an Emergency Medical Condition existed;
2. Ambulance services to an emergency room and treatment provided as part of the ambulance service;
3. Emergency room services and supplies and treatment, including professional charges, Facility charges, outpatient charges for patient observation and medical screening exams required for the stabilization of a Covered Person experiencing an Emergency Medical Condition and treatment of an injury or illness, even if confinement is not required; and
4. Prescription medications associated with an emergency, including those purchased in a foreign country.

Prior Authorization of emergency medical services will not be required prior to the point of stabilization of the Member.

**Emergency Services received from Non-Network Providers are covered as follows:**

- Emergency Services from a Non-Network Provider or Facility in Washington: We will determine a commercially reasonable Allowed Amount based on payments for the same or similar services provided in a similar geographic area. The Member's Cost Sharing responsibility will be determined using our median in-network contracted rate for the same or similar service in the same or similar geographical area. *Non-Network Providers in Washington State cannot Balance Bill you for Emergency Services.

- Emergency Services from a Non-Network Hospital in Idaho or Oregon: We will initiate negotiations with the Hospital to settle the Claim. Regardless of the amount negotiated, Ambetter will protect the Member from being Balance Billed for Emergency Services by the Hospital and the Member's maximum Cost Sharing amount will be determined using our median in-network contracted rate for the same or similar service in the same or similar geographical area.

- Emergency Services from a Non-Network Provider outside of Washington, Idaho or Oregon: We pay:
    - the amount negotiated, if any, that has been mutually agreed upon by us and the Provider as payment in full. When the Allowed Amount is negotiated, the Provider *may not* Balance Bill you for the difference between the Provider's charges and the amount negotiated; Or
    - the greatest of the following:
        1. the amount that would be paid under Medicare;
        2. the amount calculated using the same method we generally use to determine payments for out-of-network services; or

3. the contracted amount paid to Network Providers for the Covered Service—if there is more than one contracted amount with Network Providers for the Covered Service, the amount is the median of these amounts.

When the Allowed Amount is determined by one of these three methods and not negotiated, the Provider *can* Balance Bill you for the difference between what the Provider charges and amount determined.

Emergency Transport: Payment for emergency transport within the Service Area provided by non-network ambulances will be based on the Provider's billed charges or a negotiated rate. Emergency transportation outside of the Service Area will be based on the greatest of the three methods described immediately above.

**Family Planning Services**
Covered Services and supplies for Family Planning include in-network:

1. Medical history review.
2. Physical examinations.
3. Laboratory tests related to physical examinations. Prior Authorization may be required prior to receiving services.
4. Contraceptive counseling.
5. All FDA-approved contraception methods, including FDA-approved contraceptives available over-the-counter without a prescription, are covered without Cost Sharing as outlined at www.fda.gov. (See Contraception section, above.) This benefit contains both pharmaceutical and medical methods, including:
    a. Intrauterine devices (IUD), including insertion and removal;
    b. Barrier methods including: male and female condoms (limited to 60 per month), diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide and spermicide alone;
    c. Oral contraceptives including the pill (combined pill and extended/continuous use), and the mini pill (Progestin only), patch;
    d. Other hormonal contraceptives, including inserted and implanted contraceptive devices, hormone contraceptive injections and the vaginal contraceptive ring;
    e. Emergency contraception(the morning after pill);
    f. Prescription based sterilization procedures for women;
    g. FDA-approved tubal ligation; and
    h. Vasectomy and services related to this procedure.
6. For Prescription Drug contraceptives, a 12-month refill may be obtained at one time by the Member, unless the Member requests a smaller supply or the prescribing Provider instructs that the Member must receive a smaller supply. Members may receive contraceptive drugs on site at the Provider's office, if available.

Please note: The following requirements must be met for prescription birth control to be covered at 100%: (1) the drug is generic; or (2) the drug is a Brand Name Drug and (a) a generic version is not available or (b) the generic version is medically inappropriate, as determined by your healthcare Provider.

Exclusion: We will not cover Prescription Drug contraceptive refills that are obtained in the last quarter of the calendar year if a 12-month supply of the contraceptive drug was dispensed earlier during the calendar year.

**Habilitation, Rehabilitation Facility and Extended Care Facility Benefits**
Covered Services and supplies include Medically Necessary Habilitation or Rehabilitation services on an in-network Inpatient or outpatient basis. Habilitative and rehabilitative services include:

1. Inpatient Rehabilitation Facility, Extended Care Facility and professional services delivered in those Facilities including daily room and board, nursing services, diagnostic testing, x-rays and laboratory services, and prescriptions filled in the Facility. Inpatient Rehabilitation Facility and professional service charges are limited to 30 days per calendar year;
2. Outpatient physical therapy (including Medically Necessary massage therapy when provided in conjunction with physical therapy and/ or manipulation treatment), occupational therapy, speech therapy and aural therapy;
3. Braces, splints, prostheses, orthopedic appliances and Orthotic Devices, supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts;
4. Durable Medical Equipment and mobility enhancing equipment used to serve a medical purpose, including sales tax; and
5. Neurodevelopmental therapy, consisting of physical, occupational and speech therapy and maintenance to restore or improve function based on developmental delay.

Habilitative services and devices received that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and outpatient settings. We will not cover habilitative devices that do not require FDA-approval and a prescription in order to dispense.

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

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

1. The Member has reached Maximum Therapeutic Benefit.
2. Further treatment cannot restore bodily function beyond the level the Member already possesses.
3. There is no measurable progress toward documented goals.
4. Care is primarily Custodial Care.
5. When Rehabilitation services are Medically Necessary for the treatment of cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases.

**Health Management Programs Offered**

Ambetter from Coordinated Care offers the following health management programs:

1. Asthma;
2. Heart Disease;
3. Diabetes;
4. High Blood Pressure & High Cholesterol;
5. Low Back Pain;
6. Tobacco Cessation;
7. Pregnancy; and
8. Weight Loss Programs.

**Home Healthcare Service Benefits**

Covered Services and supplies for Home Healthcare are covered. Coverage is provided for Medically Necessary in-network care provided at the Member's home and includes the following:

1. Home Health Aide Services.
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for Home Healthcare.
3. I.V. medication and pain medication are Covered Services and supplies to the extent they would have been Covered Services and supplies during an Inpatient Hospital stay.

4. Medically Necessary supplies.
5. Rental or purchase of Medically Necessary Durable Medical Equipment at the discretion of the plan. At our option, we may Authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a Provider we Authorize before the purchase.
6. Sleep studies. Prior Authorization may be required prior to receiving services.

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.

For additional information on included benefits please see the sections on Ambulatory Patient Services (page 38) and Habilitation, Rehabilitation Facility and Extended Care Facility Benefits (pages 43-44).

Limitations:
See the Schedule of Benefits for benefit levels or additional limits for expenses related to Home Health Aide Services.

Exclusion:
No benefits will be payable for charges related to Respite Care, Custodial Care, or educational care except as covered under this section or the Respite Care Benefits section.

**Hospice Care Service Benefits**
Hospice care benefits are allowable for a Terminally Ill Member receiving Medically Necessary care under an in-network Hospice care program. Covered Services and supplies include:

1. Room and board in a Hospice while the Member is Inpatient.
2. Occupational therapy.
3. Speech-language therapy.
4. The rental of medical equipment while the Terminally Ill Member is in a Hospice care program to the extent that these items would have been covered under the Contract if the Member had been confined in a Hospital.
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
6. Counseling the Member regarding the Member's terminal illness.
7. Terminal Illness Counseling of the Member's Immediate Family.
8. Bereavement Counseling.

**Hospital Services**
Covered Service and supply expenses are limited to charges made by an in-network Hospital for:

1. Daily room and board and nursing services, not to exceed the Hospital's most common semi-private room rate.
2. Daily room and board and nursing services while confined in an Intensive Care Unit.
3. Skilled nursing Facility costs, including professional services and pharmacy services and prescriptions filled in the skilled nursing Facility pharmacy. Skilled nursing Facility Inpatient days for illness, injury or physical disability are limited to 60 days per calendar year.
4. Inpatient use of an operating, treatment, or recovery room.
5. Outpatient use of an operating, treatment, or recovery room for Surgery.
6. Services and supplies, including drugs and medicines, which are routinely provided by the Hospital for use only while you have Inpatient status.

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

Expenses for these services and supplies 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 limits, day or visit, if any.

**Mammograms**
Covered Service and supply expenses for routine screenings for breast cancer shall include in-network screenings at the following intervals: One (1) baseline breast cancer screening mammography for a Member between the ages of thirty-five (35) and forty (40) years. If the Member is less than forty (40) years of age and at risk, one (1) breast cancer screening mammography performed every year. If the Member is at least forty (40) years of age, one (1) breast cancer screening mammography every year and any additional mammography views that are required for proper evaluation.

Mammography screenings, which include digital breast tomosynthesis or 3D mammography, are provided in accordance with the recommendations established by the United States Preventive Services Task Force. Please refer to the Preventive Care Benefits section. If a mammography screening is not being done as a recommended preventive service, the Provider may bill the service as diagnostic rather than preventive, in which case it will be subject to the Cost Share of a diagnostic service, rather than the zero Cost Share of a preventive service.

**Mastectomy and Breast Reconstruction**
Covered Services and supplies include charges for in-network reconstructive breast Surgery and associated procedures, including internal breast prostheses, as a result of a partial or total mastectomy which resulted from illness or injury regardless of when the mastectomy was performed. Coverage includes Surgery and all stages of reconstruction of the diseased and non-diseased breast and Prosthetic Devices necessary to restore a symmetrical appearance. Complications of mastectomy services including lymphedemas are covered for any Member who has undergone a mastectomy. Covered Services and supplies include four (4) surgical bras per benefit period, as required by the Women's Health and Cancer Rights Act.

Exclusion: cosmetic services, including treatment for complications resulting from cosmetic Surgery unless for the Medically Necessary treatment of Gender Dysphoria, and complications of non-covered Surgical Services.

**Maternity and Newborn Care**
Covered Services and supplies include in-network outpatient and Inpatient pre-natal and post-partum care for the following:

1. Exams, and screenings;
2. Prenatal diagnosis of genetic disorder;
3. Laboratory and radiology diagnostic testing;
4. Infertility diagnosis (treatment is excluded);
5. In utero treatment for the fetus;
6. Health education;
7. Nutritional counseling;
8. Risk assessment;
9. Childbirth classes;
10. Vaginal or caesarean childbirth delivery in a Hospital or birthing center, including Facility Fees;
11. Complications of Pregnancy;
12. Termination of Pregnancy;

13. Services of an advanced registered nurse practitioner specialist in midwifery; or
14. Other Medically Necessary services.

Maternity coverage of a home birth by a midwife or nurse midwife is limited to low risk Pregnancy.

An Inpatient stay is covered for the mother and newborn for a minimum of 48 hours following a vaginal delivery and 96 hours following a caesarean delivery, and does not require Prior Authorization from a Physician or other healthcare Provider. There is no limit for the mother's length of Inpatient stay, where the mother is attended by a Provider who is a Physician, certified nurse midwife, physician assistant, or advanced registered nurse practitioner. The attending Provider will determine an appropriate discharge time, in consultation with the mother. However, prior or concurrent Authorization is required when a Physician or other healthcare Provider prescribes a stay over 48 hours for a vaginal delivery and 96 hours for a caesarean section.

Follow up care after discharge including the type and location of follow-up care will be determined by the attending Provider in consultation with the mother and will include but is not limited to services provided by Attending Physicians, Home Health Agencies, and registered nurses as licensed in the state of Washington.

Other maternity benefits include parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests. Comprehensive lactation support and counseling, by a trained Provider during Pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment are covered under Preventive Care Benefits.

We do not require attending Providers to obtain Prior Authorization for maternity services or care they believe to be Medically Necessary.

Maternity care for a Member's dependent daughter and services for newborns delivered of dependent daughters are covered on the same basis as the Member.

Covered Services and supplies for a newborn will be no less than the coverage for the newborn's mother and in no event will be less than 21 days even if there are separate Hospital admissions. Covered Services and supplies include: nursery services and supplies for newborns, including newly adopted children.

**Note:** This provision does not amend the Contract to restrict any terms, limits or conditions that may otherwise apply to Covered Services and supplies for maternity care. This provision also does not require a Member who is eligible for coverage under a health benefit plan to:

1. Give birth in a Hospital or other healthcare Facility; or
2. Remain under Inpatient care in a Hospital or other healthcare Facility for any fixed term following the birth of a child.

**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 Contract 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.

**Medical and Surgical Services**
We cover in-network Primary Care Provider, Network Specialists and other Medical Practitioner services. Covered Services and supplies are the following:

1. Inpatient and outpatient Physician services, including Surgery.
2. Surgery in a Physician's or Medical Practitioner's office or at an Ambulatory Surgery Center, including services and supplies.
3. Assistant surgeon services.
4. Physician and Medical Practitioner office visits including therapeutic injections and related supplies when given in a Provider's office.
5. Urgent Care Center visits, including Provider services, Facility costs and supplies.
6. Ambulatory Surgical Center services including anesthesiology, and Surgical Services and surgical supplies and Facility costs.
7. Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures.
8. Diagnostic testing (including sleep studies) using radiologic, ultrasonographic or laboratory services. Prior Authorization may be required prior to receiving some services.
9. Provider contraceptive services and supplies including but not limited to, vasectomy, tubal ligation and inserting and extraction of FDA-approved contraceptive devices. Please refer to the Family Planning provision for further information.
10. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging. Prior Authorization may be required prior to receiving some services.
11. Blood, blood products, and storage, including the services and supplies from a blood bank.
12. Home and outpatient dialysis, and the charges for processing and administration of blood or blood components.
13. The cost and administration of an anesthetic.
14. For oxygen and its administration.
15. For the following types of tissue transplants:
    a. Cornea transplants;
    b. Artery or vein grafts;
    c. Heart valve grafts;
    d. Prosthetic tissue replacement, including joint replacements;
    e. Implantable prosthetic lenses, in connection with cataracts.
16. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
17. Cochlear implants. Prior Authorization may be required prior to receiving services or supplies.
18. Medically Necessary genetic blood tests. This does not include genetic testing of a dependent child's father.
19. Medically Necessary immunizations to prevent respiratory syncytial virus (RSV).
20. Medically Necessary nutritional counseling.
21. Chemotherapy and radiation.
22. Services and supplies related to sexual reassignment Surgery when found to be Medically Necessary.
23. Infusion Therapy.
24. Medically Necessary biofeedback services.
25. Medically Necessary allergy treatment including allergy injection.

**Medical Foods**
We cover medical foods and formulas for outpatient total parenteral nutritional therapy; outpatient elemental formulas for malabsorption; and dietary formula when Medically Necessary for the treatment of Phenylketonuria (PKU), eosinophilic gastrointestinal associated disorders and inborn errors of metabolism.

Equipment and supplies for the administration of enteral and parenteral therapy are covered under Devices, Equipment and Supplies.

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

**Medically Necessary Vision Services**
Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by a Network Provider (optometrist or ophthalmologist). Covered Services and supplies include in-network office visits, testing, and treatment of eye conditions producing symptoms that if left untreated may result in the loss of vision. Please refer to the Pediatric Vision Benefits section for a list of Covered Services and supplies available for an Eligible Child under the age of 19 who is a Member.

Exclusions: The following routine and non-routine vision services are excluded:

1. Visual Therapy.
2. Any vision services, treatment or materials not specifically listed as a Covered Service or supply.
3. Two pair of glasses as a substitute for bifocals.
4. Low vision services and hardware for adults.
5. Non-network care without Prior Authorization.

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

Mental Health Services will be provided on an in-network 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 use determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not Medically Necessary will be made by a qualified licensed mental health professional.

Covered Inpatient and Outpatient mental health and/or Substance Use Disorder services are as follows:

Inpatient

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

Outpatient

1. Partial Hospitalization Program (PHP);
2. Intensive Outpatient Program (IOP);
3. Mental Health Day treatment;
4. Outpatient detoxification programs;
5. Evaluation and assessment for mental health and substance use;
6. Individual and group therapy for mental health and substance use;
7. Medication Assisted Treatment- combines behavioral therapy and medications to treat Substance Use Disorders;
8. Medication management services;
9. Psychological and Neuropsychological testing and assessment;
10. Applied Behavioral Analysis for treatment of Autism Spectrum Disorder;
11. Covered Services provided through Telemedicine or Telehealth Services;
12. Electroconvulsive Therapy (ECT); and
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 limits, day or visit, if any.

**Newborns' and Mothers' Health Protection Act Statement of Rights**
If expenses for in-network Hospital confinement in connection with childbirth are otherwise included as Covered Services and supplies, we will not limit the number of days for these expenses to less than that stated in this provision.

Under federal law, health plan issuers generally may not restrict benefits provided for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by caesarean section. However, we will provide benefits for Covered Services and supplies incurred for a shorter stay if the attending Provider (e.g., your Physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

The level of benefits and out-of-pocket costs for any later part of the 48-hour stay for a vaginal delivery or 96-hour for caesarean section will not be less favorable to the mother or newborn than any earlier part of

the stay. We do not require that a Physician or other healthcare Provider obtain Authorization for prescribing a length of stay of up to 48 hours following a vaginal delivery or 96 hours following a caesarean section. However, Prior Authorization is required when a Physician or other healthcare Provider prescribes a stay over 48 hours for a vaginal delivery and 96 hours for a caesarean section.

Note: This provision does not amend the Contract to restrict any terms, limits, or conditions that may otherwise apply to Covered Services and supplies for childbirth.

**Outpatient Medical Services and Supplies Benefits**
Covered in-network Outpatient Services and supply expenses for outpatient medical supplies include:

1. Artificial eyes or larynx, breast prosthesis, or basic artificial limbs (but not the replacement thereof, unless required by a physical change in the Member and the item cannot be modified). If more than one Prosthetic Device can meet a Member's functional needs, only the charge for the most cost effective Prosthetic Device will be considered a Covered Service.
2. One pair of foot orthotics per year per Member when Medically Necessary for treatment of diabetes only.
3. The rental of one Continuous Passive Motion (CPM) machine per Member following a covered joint Surgery.
4. The cost of one wig per Covered Person necessitated by hair loss due to cancer treatments or traumatic burns.
5. Occupational therapy following a covered treatment for traumatic hand injuries.
6. One pair of eyeglasses or contact lenses per Member following a covered cataract Surgery. See the Schedule of Benefits for benefit levels or additional limits.
7. Covered Services provided through Telemedicine or Telehealth Services.

Expenses for these services are covered if Medically Necessary and may be subject to Prior Authorization. Please see the Schedule of Benefits for more information regarding services that require Prior Authorization and specific benefit limits, day or visit, if any.

**Pediatric Vision Benefits – Children under the age of 19**
Coverage for vision services is provided for an Eligible Child, 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 vision screening;
2. Comprehensive eye exam, including dilation and with refraction every calendar year;
3. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) in glass or plastic, or initial supply of Medically Necessary contacts every calendar year;
4. One pair of prescription frames per calendar year; and
5. Low vision optical devices including low vision services, and an aid allowance with follow-up care when Authorized.

Please refer to your Schedule of Benefits for a detailed list of Cost sharing, annual maximum and appropriate service limitations.

<u>Eyeglasses</u>
Covered Service and supply expenses for lenses include single vision, lined bifocal, lined trifocal, or lenticular, in glass or plastic. If you require a more complex prescription lens, contact Member Services for Prior Authorization.

The following additional lens options (including coating and tints) are covered:

1. Progressive lenses (standard or premium);

2. Intermediate vision lenses;
3. Blended segment lenses;
4. Hi-Index lenses;
5. Plastic photosensitive lenses;
6. Photochromic glass lenses;
7. Glass-grey #3 prescription sunglass lenses;
8. Fashion and gradient tinting;
9. Ultraviolet protective coating;
10. Polarized lenses;
11. Scratch resistant coating;
12. Anti-reflective coating (standard, premium or ultra);
13. Oversized lenses;
14. Polycarbonate lenses.

Coverage includes one eyeglass frame per calendar year. Members are able to choose from a selection of eyeglass frames in a variety of sizes and colors.

Contact Lenses
Contact lenses are covered once every calendar year in lieu of the eyeglasses and frame benefits. The benefit includes contact lens evaluation, fitting, and follow-up care. If determined to be Medically Necessary, contact lenses will be covered in lieu of eyeglasses at a minimum for the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism

To see which vision Providers are part of the Network, please visit Ambetter.CoordinatedCareHealth.com or call Member Services at 1-877-687-1197.

Covered Services and supplies for non-routine vision services include eye exams for the treatment of medical conditions of the eye when the service is performed by a Network Provider (optometrist or ophthalmologist). Covered Services and supplies include office visits, testing, and treatment of eye conditions producing symptoms that if left untreated may result in the loss of vision, low vision evaluation, low vision optical devices including low vision services, and training and instruction to maximize remaining usable vision as follows:

1. One comprehensive low vision evaluation every five years;
2. High power spectacles, magnifiers and telescopes as Medically Necessary; and
3. Follow-up care of four visits in any five year period, if pre-authorized.

Exclusions: The following routine and non-routine vision services are excluded:

1. Visual therapy;
2. Two pair of glasses as a substitute for bifocals; and
3. Non-network care without Prior Authorization.

## Prescription Drug Benefits

We will provide coverage for Prescription Drugs when prescribed by a licensed and qualified Network Provider and obtained at an in-network pharmacy or through the mail order program. Coverage for Prescription Drugs includes generic, brand name, and specialty drugs.

1. Generic Drug is a drug that is the pharmaceutical equivalent to one or more Brand Name Drugs. Such Generic Drugs have been approved by the FDA as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug. Generic Drugs will be dispensed whenever available.

2. Brand drug is a Prescription Drug that has been patented and is only available through one manufacturer. Preferred Brand drugs will be dispensed if there is not a generic. Brand drugs are also often preferred because they are safer or more successful in producing a desired or intended result.
3. Non-preferred drug is a Prescription Drug covered under a higher Cost Share. This tier of drug contains both Formulary Brand Name Drugs and Generic Drugs. These drugs require higher Copay because other alternatives may be available in the lower tiers or there may be other generic equivalents available.
4. Specialty drugs are typically high-cost drugs, including but not limited to the oral, topical, inhaled, inserted or implanted, and injected routes of administration. Included characteristics of Specialty drugs are drugs that are used to treat and diagnose rare or complex diseases, require close clinical monitoring and management, frequently require special handling, and may have limited access or distribution. Specialty drugs are often also drugs that require special handling, or special or enhanced patient administration and oversight.

The appropriate drug choice for a Member is a determination that is best made by the Member and the Member's Medical Practitioner.

The drug Formulary, also known as a Preferred Drug List or PDL, is an approved list of Prescription Drugs that are covered by this Contract. The Formulary includes drugs for a variety of disease states and conditions. Periodically, the Formulary is reviewed and updated to assure that the most current and clinically appropriate drug therapies are being used. Sometimes it is Medically Necessary for a Member to use a drug that is not on the Formulary. When this occurs, the prescribing Provider may request an exception for coverage through our Member Services department. For a list of covered drugs please visit Ambetter.CoordinatedCareHealth.com or contact our Member Services department.

In addition, some of the Formulary drugs may require a Prior Authorization or step therapy requirement before coverage, or may have quantity limits. See the Prior Authorization and Step Therapy for Prescription Drugs section for more information. If you have questions regarding the Formulary or regarding your Prescription Drug benefits, call Member Services for assistance.

**Compound Medications**
Some medications that require pharmacy compounding may be covered. Compound medication that includes at least one FDA drug and is currently not FDA-approved and available commercially in the same dosage form and strength may be covered. However, any compound medication over $100/ Claim will require Prior Authorization. Specific details about which compounded medications are covered can be found by contacting Member Services at 1-877-687-1197.

**Prescription Drug Cost Sharing**
The Prescription Drug Cost Share amounts are shown on the Schedule of Benefits.

**Prescription Maximum Out-of-Pocket** means the limit or Maximum Out-of-Pocket Amount you pay for medications (during the calendar year), after you have paid your Deductible and excluding any Copays.

**Prescription Copayment or Coinsurance**
The applicable Copayment or Coinsurance applies to each thirty (30) day supply. Copayment for single and multiple 30 day supplies of a given prescription are payable at the time of delivery. Injectables that can be self-administered are also subject to the Prescription Drug Cost Sharing.

If the Copayment or Coinsurance amount is greater than the actual cost of the Prescription Drug then only the actual cost will be required to be paid.

**Prescription Drug Deductible Amount**, if applicable, means the amount shown in the Schedule of Benefits, that must be paid during any calendar year before any Prescription Drug benefits are payable. The family

Prescription Drug Deductible Amount is two times the individual Prescription Drug Deductible Amount. For family coverage, once a Member has met the individual Prescription Drug Deductible Amount, any remaining family Prescription Drug Deductible Amount can be met with the combination of any one or more Members' Eligible Service Expenses.

**Prescription Covered Services**
Covered Services and supplies are limited to charges for Formulary drugs from an in-network licensed pharmacy for:

1. Prescription Drugs; including off-label use of FDA-approved drugs as required by law or as expressly Authorized by us.
2. Any drug that under the laws of Washington may be dispensed only upon the written prescription of a Provider.
3. Certain preventive medications including, but not limited to, aspirin, fluoride, iron, and medications for Tobacco Use cessation, according to, and as recommended by, the United States Preventive Services Task Force, when obtained with a prescription.
4. Prescribed, anticancer medication including self-administered anticancer medication.
5. Diabetic supplies including insulin syringes, lancets, urine testing reagents, blood glucose monitoring reagents and insulin.
6. Prescribed medication for the treatment of hepatitis C.
7. Medically Necessary services associated with the administration of the Prescription Drug.
8. Teaching doses of self-administrable injectable medications, which are limited to three doses of medication per lifetime.

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.

Off label use of FDA-approved drugs means the prescribed use of such drug which is other than that stated in its FDA-approved labeling.

Prescription Drugs must be recognized as effective for the treatment of the condition:

1. In one of the standard reference compendia;
2. In a majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or
3. By the federal secretary of the Health and Human Services.

**Standard Reference Compendia** means (a) The American Hospital Formulary Service Drug Information, (b) The American Medical Association Drug Evaluation, (c) The United States Pharmacopoeia-Drug Information, or (d) Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the insurance commissioner.

**Peer-Reviewed Medical Literature** means scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

**Prior Authorization and Step Therapy for Prescription Drugs**
Prior Authorization is required for certain Prescription Drugs. Our Contract uses different types of restrictions to help our Members use/ take Prescription Drugs in the most effective ways. For certain drugs, you or your Provider need to get Authorization from us before we will agree to cover the drug for you. This is called "Prior Authorization." Drugs or other prescriptions not on the Formulary but determined to be

Medically Necessary and appropriate by the Provider, may be submitted for Prior Authorization to our pharmacy benefits manager via fax, phone or mail with appropriate documentation to support medical necessity. Sometimes the requirement for getting Authorization in advance helps guide appropriate use of certain drugs. If you do not get this Authorization, your drug might not be covered by the Contract. Once a Prescription Drug has been Authorized for use by a Member for a specific condition, we will not later withdraw our Authorization.

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

For certain drugs, we limit the amount of the drug that you can have. For example, the Contract might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

**Limited Access Drugs or Specialty Drugs**
Some drugs may be limited to a Specialty Pharmacy or a specific pharmacy based upon FDA-approval. These drugs will be designated in the Formulary with such limitations

If a Member received out-of-area emergency care and had a prescription filled, we require that the Claim be submitted for reimbursement no later than 1 year (365 days) following the date of service. The Claim must contain an itemized statement of expenses.

There are certain medications that are required to be covered by law. These drugs are related to the treatment of cancer, diabetes and smoking cessation. Please refer to the sections of this Contract and your Schedule of Benefits regarding these covered Prescription Drugs.

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

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

**Obtaining an Emergency Fill**
Under certain conditions, an emergency fill of a limited amount for certain medications is a Covered Service. If your dispensing pharmacy cannot reach us regarding a Prior Authorization request because it is outside of our business hours or if we are not able to reach the prescriber for full consultation, an emergency fill may be dispensed. For a list of qualifying and excluded emergency fill medications, please visit our website at https://Ambetter.CoordinatedCareHealth.com/resources/pharmacy-resources.html.

To obtain an emergency fill, your dispensing pharmacist should contact us at 1-877-687-1197 (TTY/ TDD 1-877-941-9238) to submit a request. If we find the request medically appropriate, we will Authorize for you

to receive either the minimum packaging size available at the time dispensed or up to a 7-day supply of medication. The associated Cost Share for receiving an emergency fill will be the lesser of the following:

1. Cost of the medication; or
2. The applicable pharmacy Copayment or Coinsurance for that drug, as shown on the Schedule of Benefits.

Whether subsequent fills of the same medication you received an emergency fill for is a Covered Service depends on our Prior Authorization determination. If the Prior Authorization is approved, you may obtain additional prescription fills as a Covered Service, which are subject to applicable pharmacy Cost Sharing, as shown on the Schedule of Benefits. If the Prior Authorization is not approved, additional prescription fills are non-covered under this Contract.

**Your Prescription Drug Rights**
You have the right to safe and effective pharmacy services. You also have the right to know what drugs are covered by your plan and the limits that apply. If you have a question or concern about your Prescription Drug benefits, please contact us at 1-877-687-1197 (TTY/ TDD 1-877-941-9238) or visit Ambetter.CoordinatedCareHealth.com. If you would like to know more about your rights, or if you have concerns about your plan, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900 or www.insurance.wa.gov. If you have a concern about the pharmacists or pharmacies serving you, please contact the Washington State Department of Health at 1-360-236-4700, www.doh.wa.gov, or hsqa.csc@doh.wa.gov.

Non-Covered Services and Exclusions for Prescription Drugs:
No benefits will be paid under this benefit subsection for:

1. Prescription Drugs for the treatment of erectile dysfunction or any enhancement of sexual performance, unless listed on the Formulary.
2. Prescription Drugs for weight loss unless otherwise listed on the Formulary.
3. Immunization agents otherwise not required by the Affordable Care Act and listed on the Formulary, blood, or blood plasma.
4. Medication that is to be taken by the Member, in whole or in part, at the place where it is dispensed.
5. Medication received while the Member is a patient at an institution that has a Facility for dispensing pharmaceuticals.
6. A refill dispensed more than 12 months from the date of a Physician's order.
7. More than the predetermined Managed Drug Limitations assigned to certain drugs or classification of drugs.
8. Over-the-counter (OTC) drugs that are not included in the Formulary.
9. Drugs that are labeled "Caution - limited by federal law to Investigational use" or Experimental and Investigational within the meaning as provided in this Contract.
10. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program.
11. For more than a 31-day supply when dispensed in any one prescription or refill, or for maintenance drugs up to a 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply network.
12. Prescription Drugs for any Member who enrolls in Medicare Part D as of the date of the Member's 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 section 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 for out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
15. Medications used for cosmetic purposes.
16. Replacement of lost or stolen prescriptions.
17. Infertility drugs unless otherwise listed on the Formulary.
18. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
19. Prescription Drug contraceptive refills that are obtained in the last quarter of the calendar year if a 12-month supply of the contraceptive drug was dispensed earlier during the calendar year.
20. 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.
21. For any prescription or over-the-counter version of vitamin(s) unless otherwise included on the Formulary.

**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 towards your plan Deductible or your Maximum Out-of-Pocket for any Brand Name Drug that is available as a generic version.

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

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

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

External exception request review
If we deny a request for a standard exception or for an expedited exception, the Member, the Member's designee or the Member's prescribing Physician may request that the original exception request and subsequent denial of such request be reviewed by an Independent Review Organization (IRO). The IRO will

make a determination on the external exception request and notify the Member, the Member's designee or the Member's prescribing Physician of the 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 you request external exception review of a standard exception request, we will provide coverage of the non-formulary drug for the duration of the prescription in accordance with the IRO's determination. If you request external exception review of an expedited exception request, we will provide coverage of the non-formulary drug for the duration of the exigency in accordance with the IRO's determination.

**Coverage for Pharmacy Services**
Below are frequently asked questions regarding the Pharmacy Services covered under this product:

1. Does this plan limit or exclude certain drugs my healthcare Provider may prescribe, or encourage substitutions for some drugs?
    - Our plan does limit certain drugs by utilizing Prior Authorization and step therapy criteria. Additionally, some drugs have quantity limits associated with them. Those quantity limits are based on the FDA maximum approved dose. Our plan does not categorically exclude any drug as this is prohibited under the Affordable Care Act (ACA), except as listed under the Non-Covered Services and Exclusions under this section. Access may be granted to all non-formulary drugs through the Exception Process. The Exception Process requires documentation of ineffectiveness, contraindication or intolerance to two Formulary drugs that are commonly recognized by compendia or medical literature as treatment options for the same condition. The principal tool for selection of drugs on the Formulary is the ACA mandated benchmark count tool. Additionally, drugs are considered for inclusion on the Formulary through established Pharmaceutics and Therapeutics Committee review process.

2. When can my plan change the approved drug list (Formulary)? If a change occurs, will I have to pay more to use a drug I had been using?
    - The Formulary may change as new drugs are introduced into the market, which includes generics for certain brand drugs. The expectation set forth by the ACA and by CMS is that no negative changes, such as additions of Prior Authorization, step therapy or removal of the drug from the Formulary can take place during the benefit year. Therefore, we make every effort to only make these changes to the Formulary once a year on January 1st. If there is a change in tiering or removal of the drug from the Formulary during a benefit year, the Member may be required to pay a higher Copay. In cases where the Member is negatively affected, the Member will be notified in advance of the change.

3. What should I do if I want a change from limitations, exclusions, substitutions or cost increases for drugs specified in this plan?"
    - Prior Authorization is required for these changes. You may contact Member Services at 1-877-687-1197 to request changes to the limitations, exclusions, substitutions or cost increases for drugs covered under this plan.

4. How much do I have to pay to get a prescription filled?
    - Please review your Schedule of Benefits for costs associated with filling your prescription. The Schedule of Benefits is tailored to your specific plan and outlines Cost Sharing requirements for Generic, Brand, Non-Preferred and Specialty Drugs covered by the plan.

5. Do I have to use certain pharmacies to pay the least out of my own pocket under this health plan?
    - There is no cost differentiation for in-network pharmacies. There is no coverage for prescriptions filled at out-of-network pharmacies.

6. How many days' supply of most medications can I get without paying another Copay or other repeating charge?
    - Claims for a supply of less than 31 days will incur one Copay; Claims for a supply greater than 31 but less than 61 days will incur two times Copay; Claims for supply greater than and including 61 to 90 days will incur three times Copay. This schedule of Copays applies regardless if the Claim is for exceptional supply, mail order or travel supply. Refills are allowed after Member has used up 80% of drug on hand. Vacation overrides are allowed for out-of-country travel only.
    - A pharmacist is authorized to provide one early refill of a prescription for Topical Ophthalmic products if the following criteria are met:
        i. The refill is requested at or after 70% of the predicted days of use of:
            1. The date the original prescription was dispensed; or
            2. The date that the last refill of the prescription was dispensed.
        ii. The prescriber indicates on the original prescription that a specific number of refills will be needed; and
        iii. The refill does not exceed the number of refills that the prescriber indicated on the original prescription.

7. "What other pharmacy services does my health plan cover?"
    - No additional services are provided.

**Preventive Care Benefits**
Covered Service and supply expenses for preventive care are expanded to include the charges incurred by a Member for preventive health services performed by a Network Provider in accordance with the recommendations of the United States Preventive Services Task Force (USPSTF) for evidence-based items or services that have a rating of A or B in effect. A listing of these services can be found on the USPSTF website at the following web address: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. Although these services are covered at no charge, an office visit Cost Share may apply for other Covered Services and supplies provided during your visit.

Covered Service and supply expenses include the charges incurred by a Member for the following preventive health services if appropriate for that Member in accordance with the following recommendations and guidelines:

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

5. Depression screening in adults, including pregnant and post-partum Members, children and adolescents in compliance with USPSTF recommendations.
6. Coverage for obesity or weight reduction or control services for children age six and over who qualify as obese, and adult patients who have a body mass index of 30 kg/meter squared or higher. Service include:
    a. Medical Nutritional Therapy (MNT) and Clinical Nutritional Therapy, including:
        i. Initial assessment and intervention;
        ii. Subsequent Individual Reassessment and Intervention; and
        iii. Group Appointments;
    b. Nutritional and Dietetic Counseling;
        i. Individual and Group;
    c. Annual, face-to-face IBT (Intensive Behavioral Therapy) for CVD (cardiovascular disease);
    d. Face-to-Face Behavioral Counseling for Obesity;
    e. Weight management classes, non-physician Provider; and
    f. Nutrition classes, non-physician Provider.
7. Coverage for cessation of Tobacco Use. Services include:
    a. Screening for Tobacco Use; and
    b. For those who use Tobacco products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
        i. Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without Prior Authorization; and
        ii. All Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a healthcare Provider without Prior Authorization.

Benefits for preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any Deductibles, Coinsurance Percentage provisions, and Copayment Amounts under the Contract when the services are provided by a Network Provider. Covered Services and supplies provided outside of these recommended guidelines are not covered and may be applied to your Deductible or other Cost Sharing. Please be aware that covered Preventive Care Benefits accessed at a Hospital Based Provider's office may result in additional Facility or professional fees that will be your responsibility, subject to applicable Cost Sharing.

If a service is considered diagnostic or non-preventive care, your plan's Cost Sharing will apply. It is important to know what type of service you are 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 Services and supplies for preventive care expense and chronic disease management benefits may include the use of reasonable medical management techniques authorized by federal law to promote the use of high value Preventive Care Services from Network Providers. Reasonable medical management techniques may result in the application of Cost Sharing to services when a Member chooses not to use a high value service that is otherwise exempt from Deductibles, Coinsurance provisions, and Copayment Amounts, when received from a Network Provider. Such medical management techniques include but are not limited to the usage of nationally accepted criteria such as InterQual, McMillan, National Coverage Determinations, and Local Coverage Determinations in addition to recognized Standards of Care Guidelines and governing agency rules such as NCQA, URAC and the State.

As new recommendations and guidelines are issued, those services will be considered Covered Services and supplies 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.

**Prostate Cancer Screening**
Covered Services and supplies include prostate screenings ordered by a Network Provider for determining the presence of precancerous or cancerous conditions and other health problems. Please refer to the Preventive Care Benefits section.

**Respite Care Benefits**
Respite Care is covered on an in-network Inpatient, home, or outpatient basis to allow temporary relief to family members from the duties of caring for a Member under Hospice care. Respite days that are applied toward the Deductible are considered benefits provided and shall apply against any maximum benefit limit for these services. See your Schedule of Benefits for coverage information.

**Routine Foot Care**
Routine foot care services are covered when Medically Necessary for the in-network treatment of diabetes. If Medically Necessary for the treatment of diabetes, the Contract will cover orthopedic shoes, arch supports, foot orthotics, shoe lifts and wedges. The Contract will not cover routine foot care except when Medically Necessary for treatment of diabetes.

**Social Determinants of Health Supplemental Benefits**
Social Determinants of Health supplemental benefits and services may be offered to Members 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 Members 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 Members. 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 Members through the "My Health Pays" program and through local health plan websites. Members 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.CoordinatedCareHealth.com or by contacting Member Services at 1-877-687-1197 (TTY/TDD 1-877-941-9238).

**Transplant Benefits**
Covered Services and supplies for transplant service expenses:
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.

If a Member is an appropriate candidate for a Medically Necessary transplant, the following Covered Services and supplies provided in either a Hospital or outpatient setting will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting.
3. Pre-transplant stabilization, meaning an Inpatient stay to Medically Stabilize a Member to prepare for a later transplant, whether or not the transplant occurs.

4. Peripheral stem cell collection.
5. The transplant itself, not including the acquisition cost for the organ or bone marrow.
6. The transplant Facility Fees, performed in either a Hospital or outpatient setting.
7. Post-transplant follow-up.

Artificial or mechanical devices designed to replace a human organ temporarily or permanently will be covered based on our medical guidelines and the manufacturer recommendations.

A Member may obtain services in connection with a transplant from any Physician.

Transplant Donor Expenses:
We will cover the Medically Necessary services incurred by a live donor if:

1. They would otherwise be considered Covered Services and supplies under the Contract;
2. The Member received an organ or bone marrow of the live donor; and
3. The transplant was Authorized as a Medically Necessary transplant.

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these Transplant 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 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 transplant.
8. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the FDA regulation, regardless of whether the trial is subject to USFDA oversight.

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

1. Covered Services and supplies for a transplant will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits.
2. The acquisition cost for the organ or bone marrow is not covered.

**Urgent Care**
Urgent Care services is care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not severe enough to require emergency room care. 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 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 contracted 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 which care most appropriate for your

specific need. If you believe you are having a medical emergency, please call 911 or visit an emergency department.

**Vision Benefits - Adults 19 years of age or older**
Coverage for vision services is provided for adults, age 19 and older, from a Network Provider. In-network routine eye exams, prescriptions eyeglasses, and standard contact lenses are covered and are managed through your vision vendor. 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 Ambetter.CoordinatedCareHealth.com or call Member Services at 1-877-687-1197.
You may receive one routine eye exam, including dilation and with refraction, and eyewear once every calendar year. Eyewear includes either one pair of eyeglasses or initial supply of standard contacts.

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

For your maximum allowance for eyeglass frames please refer to your specific plan information listed in the Schedule of Benefits. Covered frames are to be selected from your vision vendor's frame Formulary.

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

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

Exclusions: The following routine and non-routine vision services are excluded:
1. Visual therapy;
2. Low vision services and hardware for adults; and
3. Non-network care without Prior Authorization.

**Wellness and Other Program Benefits**
Benefits may be available to Members for participating in certain programs that we may make available in connection with this Contract. Such programs may include wellness programs, disease or Care Management programs, and other programs as found under the Health Management Programs Offered provision. You may obtain information regarding the particular programs available at any given time by visiting our website at Ambetter.CoordinatedCareHealth.com or by contacting Member Services by telephone at 1-877-687-1197 (TTY/TDD 1-877-687-1197). The benefits are available as long as coverage remains active, unless changed by us as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All Members are automatically eligible for program benefits upon obtaining coverage. The programs are optional, and the benefits are made available at no additional cost to the Members. The programs and benefits available at any given time are made part of this Contract by this reference and are subject to change by us through updates available on our website or by contacting us.

# PRIOR AUTHORIZATION

**Prior Authorization Required**
Some Covered Services require Prior Authorization. In general, when your Primary Care Provider or other Network Provider recommends care that needs Prior Authorization, it is up to the Network Provider to obtain Authorization from us prior to providing a service or supply to a Member. Network Providers cannot bill you for services for which they fail to obtain Prior Authorization as required. However, there are some Network Eligible Services for which you, the Member, 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 (See the "Services from Non-Network Providers" in this section for further details);
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**
Prior Authorization requests must be received by phone/ efax/ Provider portal as follows:

1. At least 5 days prior to an elective non-urgent 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 Healthcare, except those Members needing Home Healthcare after Hospital discharge when possible.

**Prior Authorization Determination and Notification**
After Prior Authorization has been requested and all required or applicable documentation has been submitted, we will notify you and your Provider of our decision as follows:

1. For Inpatient services that require concurrent review, within 24 hours of receipt of the request.
2. For expedited pre-service requests, within 2 days of receipt, but not longer than 5 days if we need to request additional information.
3. For standard non-urgent pre-service requests, within 5 days of receipt, but not longer than 14 days if we need to request additional information.
4. For post-service review 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 1-877-687-1197 (TTY/ TDD 1-877-941-9238) before the service or supply is provided to the Member. You can also view your Authorization status using your secure Member portal. To register, go to Ambetter.CoordinatedCareHealth.com/resources.html.

Prior Authorization by us entitles a Member to receive Covered Services from a specified healthcare Provider. Services shall not exceed the limits of the Authorization and are subject to all terms and conditions of this Contract. Prior Authorization approvals will not expire sooner than 45 days from the date of our determination. Members who have a complex or serious medical or psychiatric condition may receive a standing Authorization for specialist services.

**Emergency Services**
In cases of Emergency Services received due to an Emergency Medical Condition, 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. If we require Prior Authorization for post-evaluation or post-stabilization services, we will provide access to an Authorized Representative twenty-four hours a day, seven days a week, to facilitate review.

In the event we do Authorize coverage of Emergency Services, we will not subsequently retract our Authorization after the Emergency Services have been provided, or reduce payment for an item or service furnished in reliance on Prior Authorization, unless the Authorization was based on a material misrepresentation about the Member's health condition made by the Provider of Emergency Services.

Coverage of Emergency Services is subject to any applicable Cost Sharing.

**Services from Non-Network Providers**
Except for emergency medical services, we do not cover services received from Non-Network Providers. If a situation arises where a Covered Service cannot be obtained from a Network Provider located within the access standards established by us, and we confirm that no Network Provider is otherwise available, we will provide a Prior Authorization for you to obtain the service from a designated 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.

When a non-emergency Covered Service is received from a Non-Network Provider as Authorized by us, and there were a sufficient number and type of Network Providers available to provide that particular Covered Service, the Allowed Amount is either:

- the amount negotiated, if any, that has been mutually agreed upon by us and the Provider as payment in full. When the Allowed Amount is negotiated, the Provider *may not* Balance Bill you for the difference between what the Provider charges and amount negotiated; or
- the amount that would be paid under Medicare. When the Allowed Amount is set by Medicare, the Provider *may* Balance Bill you for the difference between what the Provider charges and amount set by Medicare.

If there are an insufficient number of Network Providers or Provider-types in your area necessary to provide a particular Covered Service, we will ensure that you can obtain the Covered Service from a Provider or Facility within a reasonable proximity, regardless of whether the service is the result of an Emergency Medical Condition. You must request Prior Authorization from us prior to receiving non-emergency services from a Non-Network Provider or non-network Facility. In any such case, the Allowed Amount will be the lesser of:

- the amount negotiated, if any, that has been mutually agreed upon by us and the Non-Network Provider as payment in full, or
- the amount reasonably accepted by the Non-Network Provider (not to exceed the Provider's Billed Amount).

Regardless of the Allowed Amount, you will be able to receive the Covered Service at no greater cost than if the service were obtained from a Network Provider.

# GENERAL NON-COVERED SERVICES AND EXCLUSIONS

This Contract only covers certain Medically Necessary Covered Services. If you are uncertain about whether a service or material is covered please contact Member Services before the service or material is provided.

**No benefits will be provided or paid for:**

1. Any service or supply that would be provided without cost to the Member in the absence of insurance covering the charge.
2. Expenses, fees, taxes or surcharges imposed on the Member by a Provider (including a Hospital) but that are actually the responsibility of the Provider to pay.
3. Any services performed for a Member by a Member's Immediate Family.
4. Any services not identified and included as Covered Services under the Contract. You will be fully responsible for payment for any services that are not Covered Services.

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

1. Administered or ordered by a Physician or Medical Practitioner; and
2. Medically Necessary to the diagnosis or treatment of an injury or illness, or covered under the Preventive Care Benefits provision.

**Excluded services are:**

1. For services or supplies that are provided prior to the Effective Date or after the termination date of this Contract, except as expressly provided for under the Benefits After Coverage Terminates clause in this Contract's Termination section.
2. For any portion of the charges that are in excess of the Eligible Service Expense.
3. Any services or materials for non-emergency or non-urgent care received outside the United States.
4. Any service or material that requires Prior Authorization under this Contract by the Member, not the Network Provider, and where no Prior Authorization has been obtained by the Member.
5. Routine foot care, except for the treatment of diabetes.
6. Services or supplies for which no charge is made, or for which a charge would not have been made if the Member had no healthcare coverage or for which the Member is not liable.
7. Services provided by a member of the Member’s family.
8. Services or supplies for weight modification, including but not limited to surgical treatment of obesity, wiring of the teeth, all forms of intestinal bypass Surgery, bariatric Surgery and weight loss programs, except as specifically covered in the Health Management section of the Contract.
9. For cosmetic breast reduction or augmentation, except for the Medically Necessary treatment of Gender Dysphoria.
10. Infertility treatment and reversal of sterilization and reversal of vasectomies.
11. For expenses for television, telephone, or expenses for other persons.
12. For telephone consultations, except those provided by Teladoc and meeting the definition of Telemedicine or Telehealth Services, or for failure to keep a scheduled appointment.
13. For Dental Service expenses, including orthodontia, braces for any medical or dental condition, Surgery and treatment for oral Surgery, except as expressly provided for under the Covered Services provision.
14. For Cosmetic Treatment, including when it is incidental to or follows Surgery or an injury that was covered under the Contract, with the exception of Reconstructive Surgery, Medically Necessary treatment of Gender Dysphoria or services performed to correct a congenital anomaly or birth defect in a child who has been a Member from its birth until the date Surgery is performed.

15. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Benefits provision.
16. For eye refractive Surgery, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
17. For vocational, recreational therapy, and vocational Rehabilitation.
18. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.
19. For hearing aids other than cochlear implants, except as expressly provided in this Contract.
20. For Experimental or Investigational treatment(s) services. The fact that an Experimental or Investigational treatment 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 of that particular condition. Any service excluded based on Experimental or Investigational status will be done so in writing within twenty (20) working days of receipt of a fully documented request. We may extend the review period beyond twenty (20) days only with the informed written consent of the Member.
21. For treatment received outside the United States, except for an Emergency Medical Condition or prescription medications associated with an Emergency Medical Condition 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 Member is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a Member's right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a Member's 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. 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 birthed by a Surrogate Member 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 Members possessing an active policy with us and/ or the child possesses an active policy with us at the time of birth.
24. For or related to treatment of hyperhidrosis (excessive sweating).
25. For fetal reduction Surgery, unless Medically Necessary.

# GENERAL NON-COVERED SERVICES AND EXCLUSIONS (Continued)

26. For the following miscellaneous items: artificial insemination (except where required by federal or state law); care or complications resulting from non-covered services; domiciliary care; home test kits; care or services provided to a non-member biological parent; nutrition or dietary supplements, when not Medically Necessary; pre-marital lab work; processing fees; Rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the Service Area; sclerotherapy for varicose veins; treatment of spider veins; non-emergency transportation expenses, unless specifically described in this Contract.
27. Private duty nursing.
28. Custodial Care.
29. Orthognathic Surgery and supplies unless due to Temporomandibular Joint (TMJ) disorder or injury, sleep apnea or congenital anomaly.
30. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
31. For mental health exams and services involving:
    a. 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. Testing of aptitude, ability, intelligence or interest;
    c. Services which are custodial or residential in nature; or
32. Habilitative Services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.

# TERMINATION

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this Contract.
2. The date of termination that the Exchange provides us upon your request of cancelation.
3. The date we decline to renew this Contract, as stated in the Discontinuance provision of this Contract.
4. The date of your death.
5. The date a Member's eligibility for coverage under this Contract ceases as determined by the Exchange.
6. For an Eligible Child reaching the limiting age of 26, coverage under this Contract, for an Eligible Child, will terminate at 11:59 p.m. PST on the last day of the year in which the Eligible Child reaches the limiting age of 26.

Paid premiums that are not earned due to Contract termination will be refunded.

An enrolled Dependent Member who would cease to be a qualified family member by reason of termination of marriage or your death may choose to continue under the Contract. An enrolled Dependent Member will replace you as the Primary Member and a proper adjustment will be made in the premium required for this Contract to continue. Premiums paid and not earned due to your death will be refunded.

**Discontinuance**
90 Day Notice: If we discontinue offering and decide not to renew all Contracts issued on this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 90 days prior to the date that we discontinue coverage. You will be offered an option to purchase any other coverage in the individual market we offer in your state at the time of discontinuance of this Contract. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180 Day Notice: If we discontinue offering and decide not to renew all individual Contracts in the individual market in the state where you reside, we will provide a written notice to you and the Commissioner of Insurance at least 180 days prior to the date that we stop offering and terminate all existing individual Contracts in the individual market in the state where you reside.

**Notification Requirements**
It is the responsibility of you or your former lawful Spouse or state registered domestic partner to notify us within thirty-one (31) days of your legal divorce.

**Benefits After Coverage Terminates**
A Member who is receiving Covered Services as a registered bed patient in a Hospital on the date of termination shall continue to be eligible for Covered Services while an Inpatient for the condition which the Member was hospitalized until one of the following events occurs:

1. According to clinical criteria, it is no longer Medically Necessary for the Member to be an Inpatient at the Facility.
2. The Member becomes covered under another Contract with a group health plan that provides benefits for the hospitalization.
3. The Member becomes enrolled under a Contract with another carrier that would provide benefits for the hospitalization if the Contract did not exist.

All the terms and conditions of this Contract, including those stated in the Premiums section of this Contract, will still apply while benefits are continued during hospitalization.

The Benefits After Coverage Terminates provision does not apply:

1. If you are covered under another Contract that provides benefits for the hospitalization at the time coverage would terminate, except as provided in the Portability of Coverage provision in this section; or
2. If your coverage is terminated because of:
    a. A request by you;
    b. Fraud or material misrepresentation on your part; or
    c. Your failure to pay premiums.

# REIMBURSEMENT AND SUBROGATION

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

If this plan provides benefits under this Contract to a Member for expenses incurred due to third party injuries, then the plan 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 to the extent permitted by Washington law. The plan's rights of recovery apply to any recoveries made by or on behalf of the Member from any sources, including but not limited to:

1. Payments made by a third party or any insurance company on behalf of the third party;
2. Any payments or awards under an uninsured or underinsured motorist coverage policy;
3. Any workers' compensation or disability award or settlement;
4. Medical payments coverage under any automobile policy, premises or homeowners medical payment coverage or premises or homeowners insurance coverage; and
5. 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 the plan's right of subrogation. When this plan provides healthcare benefits for expenses incurred due to third party injuries, the plan 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 to the extent permitted by Washington law. The plan may proceed against any party with or without the Member's consent.

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

The Member has a right to be fully compensated prior to us invoking our right of subrogation or reimbursement.

As a condition for our payment, the Member or anyone acting on the Member's 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 promptly inform us in writing of any claim made or lawsuit filed on behalf of a Member in connection with the loss.
3. To include the amount of benefits paid by us on behalf of a Member in any claim made against any third party.
4. That we:
    a. Will have a lien on all money received by a Member in connection with the loss equal to the benefit amount we have provided or paid.
    b. May give notice of that lien to any third party or third party's agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect our rights.

d. Are subrogated to all of the rights of the Member against any third party to the extent of the benefits paid on the Member's behalf.
e. May assert that subrogation right independently of the Member.

5. To take no action that prejudices our reimbursement and subrogation rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan to the extent permitted by Washington law.
6. To sign, date, and deliver to us any documents we request that protect our reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a third party without providing us with written notice no less than 30 days prior to the settlement.
8. To reimburse us from any money received from any third party, to the extent of benefits we paid for the illness or injury, whether obtained by settlement, judgment, or otherwise, and whether or not the third party's payment is expressly designated as a payment for medical expenses.
9. That we may reduce other benefits under the Contract by the amounts a Member has agreed to reimburse us.

Our subrogation and reimbursement rights shall be limited to the excess of the amount required to fully compensate the Member for the loss sustained, in accordance with applicable law.

Subject to the above provisions, if the Member is entitled to or does receive money from any source as a result of the events causing the injury or illness, including but not limited to any liability insurance or uninsured/underinsured motorist funds, our Contract benefits are secondary, not primary.

If the Member takes no action to recover money from any source, then the Member agrees to allow us to initiate our own direct action for reimbursement or subrogation.

To the extent that the Member recovers funds from any source that may serve to compensate for medical injuries or medical expenses, the Member agrees to hold such monies in trust or in a separate identifiable account until our subrogation and reimbursement rights are fully determined and that we have an equitable lien over such monies to the full extent of our Contract payments and/or the Member agrees to serve as constructive trustee over the monies to the extent of our Contract payments.

If reasonable collections costs have been incurred by an attorney for the Member in connection with obtaining recovery, under certain conditions, we will reduce the amount of reimbursement by the amount of an equitable apportionment of such collection costs between us and the Member. This reduction will be made only if each of the following conditions have been met: (i) we receive a list of the fees and associated costs before settlement and (ii) the Member’s attorney’s actions were reasonable and necessary to secure recovery.

Implementation of this section shall be deemed a part of Claims administration under the Contract and we shall therefore have discretion to interpret its terms.

# COORDINATION OF BENEFITS

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

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

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

A **Plan** is any of the following that provides benefits or services for medical care or treatment or treatment. A plan includes group, individual or blanket disability insurance contracts, and group or individual contracts issued by healthcare service contractors or health maintenance organizations (HMO), Closed Panel Plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

Plan does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

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

The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when you have healthcare coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the Claim equal 100% of the total Allowable Expense for that Claim. This means that when this Plan is secondary, it must pay the amount that which, when combined with what the Primary Plan paid, totals 100% of the highest Allowable Expense. In addition, if this Plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary Plan) and record these savings as a benefit reserve for you. This reserve must be used to pay any expenses during that calendar year, whether or not they are an Allowable Expense under this Plan. If this Plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

**Allowable Expense** except as outlined below is a healthcare expense, including Deductibles, Coinsurance and Copayments, and without reduction for any applicable Deductible, that is covered at

least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. When coordinating benefits, any Secondary Plans must pay an amount which, together with the payment made by the Primary Plan, cannot be less than the same allowable expense as the Secondary Plan would have paid if it was the Primary Plan. In no event will a Secondary Plan be required to pay an amount in excess of its maximum benefit plus accrued savings.

1. If you advise us that all plans covering you are high-deductible health plans and you intend to contribute to a health savings account established according to Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's Deductible will not be considered an allowable expense, except for any healthcare expense incurred that may not be subject to the Deductible as described in Section 223 (c)(2)(C) of the Internal Revenue Code of 1986.
2. An expense that is not covered by any Plan covering you is not an Allowable Expense.
3. When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the allowable expense.

The following are examples of expenses that are not Allowable Expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If you are covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If you are covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred Provider arrangements.

**Closed Panel Plan** is a Plan that provides healthcare benefits to you in the form of services through a panel of Providers who are primarily employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel Member.

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

**Order of Benefit Determination Rules**

When you are covered by two or more plans, the rules for determining the order of benefit payments are as follows. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan. A plan that does not contain a coordination of benefits provision that is consistent with chapter 284-51 of the Washington Administrative Code is always primary unless the provisions of both Plans state that the complying plan is primary, except coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the Plan provided by the Contract holder. Examples include major medical coverage that are superimposed over Hospital and surgical benefits, and insurance type coverage that are written in connection with a Closed Panel Plan to provide out-of-network benefits. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan. Each Plan determines its order of benefits using the

first of the following rules that apply:

**Non-Dependent or Dependent**
The plan that covers you other than as a dependent, (for example as an employee, Member, Contract holder, subscriber or retiree) is the Primary Plan and the Plan that covers you as a dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a dependent, and primary to the Plan covering you as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering you as an employee, Member, Contract holder, subscriber or retiree is the Secondary Plan and the other plan is the Primary Plan.

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

1. For a child whose parents are married or are living together, whether or not they have ever been married:
    a. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    b. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    a. If a court decree states that one of the parents is responsible for the child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's Spouse does, then that parent's Spouse's plan is the Primary Plan. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree;
    b. If a court decree states one parent is to assume primary financial responsibility for the child but does not mention responsibility for healthcare expenses, the plan of the parent assuming financial responsibility is primary;
    c. If a court decree states that both parents are responsible for the child's healthcare expenses or healthcare coverage, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits;
    d. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the child, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits; or
    e. If there is no court decree allocating responsibility for the child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
        i. The Plan covering the Custodial Parent, first;
        ii. The Plan covering the Spouse of the Custodial Parent, second;
        iii. The Plan covering the non-custodial parent, third; and then
        iv. The Plan covering the Spouse of the non-custodial parent, last.
3. For a child covered under more than one Plan of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for child(ren) whose parents are married or are living together or for child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

**Active Employee or Retired or Laid-off Employee**
The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering you as a retired or laid-off employee is the Secondary Plan. The same would

hold true if you are a dependent of an active employee and you are a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

**COBRA or State Continuation Coverage**
If your coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering you as an employee, Member, subscriber or retiree or covering you as a dependent of an employee, Member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

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

**Effect on the Benefits of This Plan**
When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the total Allowable Expenses. In determining the amount to be paid for any Claim, the Secondary Plan must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the Claim equal 100% of the total Allowable Expense for the Claim. Total Allowable Expense is the highest Allowable Expense of the Primary Plan or the Secondary Plan. In addition, the Secondary Plan must credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other healthcare coverage. If this plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

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

**Facility of Payment**
If payments that should have been paid by us are paid by another plan, we have the right, at our discretion, to remit to the other Plan the amount we determine appropriate to satisfy the intent of this provision. The amounts paid to the other plan are considered benefits paid by us. To the extent of such payments, we are fully discharged from liability under this plan.

**Right of Recovery**
We have the right to recover excess payment whenever we have paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. We may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans. If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your Network Provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you

know within thirty calendar days.

**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.

When a person is eligible for Medicare benefits, and Medicare is deemed to be the primary bill payer under Medicare secondary payer guidelines and regulations, we will reduce our payment by the Medicare primary payment and pay as secondary up to the Medicare allowable amount. However, under no circumstances will this plan pay more than it would have paid if it had been the Primary Plan.

Members may no longer be eligible to receive a premium subsidy for the Washington Health Benefit Exchange plan once Medicare coverage becomes effective.

***CAUTION:*** All health plans have timely Claim filing requirements. If you or your Provider fail(s) to submit your Claim to a secondary health plan within that plan's Claim filing time limit, the plan can deny the Claim. If you experience delays in the processing of your Claim by the primary health plan, you or your Provider will need to submit your Claim to the secondary health plan within its Claim filing time limit to prevent a denial of the Claim. To avoid delays in Claim processing, if you are covered by more than one plan you should promptly report to your Providers and plans any changes in your coverage. If you have questions about this Coordination of Benefits provision, please contact the Washington State Office of the Insurance Commissioner.

# CLAIMS

Your healthcare benefits are paid according to the conditions in this section. If you paid Providers for services this section will outline the process you should follow if you need to be reimbursed.

Generally, you will not have any Claims to file or Claim forms to fill out for medical services received from Network Providers. Your Network Provider will bill us directly. However, most Covered Services do require a Cost Sharing amount. Please refer to the Cost Sharing section of this Contract and your Schedule of Benefits for your Cost Sharing responsibility.

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

In no event, except the absence of legal capacity, shall a Claim be accepted later than one (1) year from the date of service.

**Services from Network Providers**
We pay Network Providers directly for Covered Services provided to Members. You should not be required to pay sums to a Network Provider for Covered Services except for required Cost Sharing amounts. You will be responsible for payment of charges for missed appointments or appointments canceled without adequate notice.

If you are asked by a Network Provider to make any payments for Covered Services in addition to the Cost Sharing amounts in this Contract or your Schedule of Benefits, you should contact Member Services at 1-877-687-1197 (TTY/ TDD 1-877-941-9238) before making any additional payments. You are not liable to a Network Provider for any amounts that we owe the Provider.

If you receive a bill for services you believe are covered under this Contract, you must within ninety (90) days of the date of service, or as soon thereafter as reasonably possible, either:

1. Contact Member Services. If a Claim has already been submitted to Ambetter by your Provider, we can provide information about its status. If we have not received a Claim, we will work with you or your Provider to obtain one; or
2. If you have already paid the bill, you can submit a Claim for reimbursement of Covered Services to:

**Ambetter from Coordinated Care**
**Attn: Claims Department – Member Reimbursement**
**P.O. Box 5010**
**Farmington, MO 63640-5010**

The Member Reimbursement Medical Claim Form may be found online at:
https://Ambetter.CoordinatedCareHealth.com/resources/handbooks-forms.html.

**Services from Non-Network Providers**
Except for emergency medical services you must receive Prior Authorization before receiving services from a Non-Network Provider. Otherwise you may be responsible for all charges incurred.

If you receive Authorization to obtain services from a Non-Network Provider you may be required to make full payment to the Non-Network Provider at the time services are rendered. You should then submit satisfactory evidence to us that such payment was made to the Non-Network Provider. Upon review and approval of the evidence of payment, we will reimburse you for Covered Services less any required Cost Sharing that you would have been required to pay had the services been obtained from a Network Provider.

You will be responsible for any charges not specifically Authorized or covered by us. Alternatively, you may also ask the Provider to submit a Claim to us for payment.

**Emergency Services from Non-Network Providers**
If you receive Emergency Services due to an Emergency Medical Condition from a Non-Network Provider, please ask your Provider to submit a Claim to Coordinated Care for the services rendered. If your Provider is unwilling to submit a Claim, you are responsible for submitting the Claim. The Claim must contain an itemized statement of treatment, expenses, and diagnosis, as well as any other information that we request in the process of handling your Claim. If you are submitting the Claim, then the itemized Claim or statement must be submitted to us as soon as possible at the following address:

**Ambetter from Coordinated Care**
**Attn: Claims Department – Member Reimbursement**
**P.O. Box 5010**
**Farmington, MO 63640-5010**

Upon review and approval of the evidence of payment, we will reimburse you the Eligible Service Expense amount for Covered Services less any required Cost Sharing that you would have been required to pay had the services been obtained from a Network Provider. Depending on the circumstances, we may also pay the Claim to the Provider and ask the Provider to reimburse you. You may be responsible for charges not specifically covered by us.

Please note: The bill you receive for services or supplies from a Non-Network Provider may be significantly higher than the Eligible Service Expense for those services or supplies from a Network Provider. In addition to any applicable Deductible Amount, Copayment Amount, and/or Coinsurance, you may be responsible for the difference between the Eligible Service Expense and the amount the Non-Network Provider bills you for the services or supplies. Any amount you are obligated to pay to the Non-Network Provider in excess of the Eligible Service Expense will not apply to your Deductible Amount or out-of-pocket maximum.

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

1. Sign, date and deliver to us authorizations to obtain any medical or other information, records or documents.
2. Obtain and furnish to us, or our representatives, medical or other information, records or documents.
3. Answer, under oath or otherwise, any questions which we or our representatives may ask.
4. Furnish any other information, or assistance that we may require, including 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 needed for review).

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

**Foreign Claims Incurred For Emergency Care**
Claims incurred outside of the United States for Emergency Services and treatment of a Member must be submitted in English or with an English translation and translated into U.S. currency. Foreign Claims must also include the applicable medical records in English to show proper evidence of payment to the Provider.

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

Upon request by the custodial parent, we will:

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

A custodial parent may, with our approval, assign Claim payments to the Hospital or Medical Practitioner providing treatment to an Eligible Child.

**Right to Receive and Release Necessary Information and Medical Records**
Your personal health information may be requested or disclosed by us if necessary to help you get medical care, to pay your Claims or for operational purposes like Care Management or to improve the quality of care you receive.

The following is a non-exclusive list of healthcare Providers and types of information that we may request or disclose to help in your treatment payment of your Claims or other operational purposes:

1. Other insurance carriers or group health plans;
2. Any other institution providing care, treatment, consultation, drugs or supplies;
3. Clinics, Hospitals, long-term care or other medical Facility; or
4. Physicians, dentists, pharmacists or other physical or behavioral healthcare Providers;
5. Billing statements;
6. Claim records;
7. Correspondence;
8. Dental records;
9. Diagnostic imaging reports;
10. Hospital records (including nursing records and progress notes);
11. Laboratory reports; and
12. Medical records.

We are required by law to protect your personal and health information. We must obtain prior written authorization from you before we release any information not related to routine treatment, payment and operational purposes. You may request a copy of our Notice of Privacy Practices by calling our Member Services department at 1-877-687-1197 (TTY/ TDD 1-877-941-9238), or visiting our website at Ambetter.CoordinatedCareHealth.com.

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

**No Third Party Beneficiaries**
This Contract is not intended to, nor does it, create or grant any rights in favor of any third party, including but not limited to any Hospital, Provider or Medical Practitioner providing services to you. This Contract shall not be construed to create any third party beneficiary rights.

# GRIEVANCE AND APPEAL PROCESS

We hope you will always be satisfied with us and our Providers. If you are not satisfied, please let us know. We offer the following processes if you are dissatisfied with the services you receive or a decision that we make:

1. Grievance Process – use this process to express a Complaint or dissatisfaction about customer service or the quality or availability of a health service.
2. Appeal Process – use this process to ask us to reconsider a decision (Adverse Benefit Determination) we made regarding your benefits or a Claim.
3. External Review by an Independent Review Organization – this process is available for Members who are not satisfied with the final outcome of the Internal Appeal process.

Coordinated Care will assist you through the Grievance or Appeal process and will respond in a timely and thorough manner. We will ensure that the processes are accessible to enrollees who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that affect their ability to file a Grievance or an Appeal.

We will not retaliate against you or your Representative for filing a Grievance or an Appeal. We will not take, or threaten to take, any punitive action against a Provider acting on behalf or in support of any Member filing a Grievance or Appeal.

**Representative** means someone who represents you for the purpose of an Appeal or Grievance. The Representative may be your treating Provider or can be another party, such as a family member or friend, as long as you or your legal guardian authorize, in writing, our disclosure of your protected health information for the purpose of an Appeal. No authorization is required from the parent(s) or legal guardian of a Member who is an unmarried and dependent child and is less than 14 years old. A healthcare professional with knowledge of your medical condition is recognized as your Representative and can request an Appeal of a Prior Authorization denial on your behalf without your consent. Even if you have previously designated a person as your Representative in a previous Appeal, an authorization designating that person as your Representative in a new Appeal will be required (but re-designation is not required for each Appeal level). If no authorization exists and is not received during the course of an Appeal, the determination and any personal information will only be disclosed to you and your treating Provider.

## GRIEVANCE PROCESS

Coordinated Care strives to ensure that all interactions are positive and takes seriously any expression of dissatisfaction. Grievances can be related to health plan customer service or the quality or availability of a health service. Many Grievances can be resolved immediately on the phone. Coordinated Care will work to fully document, investigate and resolve any of your questions, concerns and Grievances.

### How to File a Grievance

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

To file a Grievance, call Member Services at 1-877-687-1197 (TTY/ TDD 1-877-941-9238). You can also write a letter and mail or fax your Grievance to Coordinated Care at 855-218-0588. A Grievance and Appeal Form may be found online at: https://Ambetter.CoordinatedCareHealth.com/resources/handbooks-forms.html. Be sure to include:

1. Your first and last name.
2. Your Member ID number.
3. Your address and telephone number.

4. What you are unhappy with.
5. Any supporting documentation, (e.g., date and location of service, Claim number, Provider name, etc.).
6. What you would like to have happen (desired outcome).

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

Grievances Coordinator
Coordinated Care
1145 Broadway, Suite 300
Tacoma, WA 98402

The Grievance Coordinator will send you a letter within 5 business days of receiving your written Grievance or a Member Services representative's summary. The letter will let you know that we have received your Grievance and the expected date of resolution. The letter also serves as both a written record of your Grievance as well as an acknowledgement.

If someone else is going to file a Grievance for you, we must have your written permission for that person to file a Grievance or Appeal on your behalf. You will need to obtain and fill out an Authorization to Disclose Health Information Form, and return it to us so that we will know who you have granted permission to represent you. The Authorization to Disclose Health Information Form can be obtained by calling Member Services at 1-877-687-1197 (TTY/ TDD 1-877-941-9238) or by visiting our website at https://Ambetter.CoordinatedCareHealth.com/resources/handbooks-forms.html.

If you have any proof or information that supports your Grievance, you may send it to us and we will add it to your case. You may supply this information to Coordinated Care by email, fax, in person, or other written method. You may also request to receive copies of any documentation that Coordinated Care used to make the decision about your care, Grievance, or Appeal. We may need to obtain additional information to review your request. If a signed Authorization to Disclose Health Information Form & Revocation of Authorization Form is not included with your Grievance, a form will be sent to you for your signature. If a signed authorization is not provided within 30 calendar days of the request, Coordinated Care may issue a decision on the Grievance without review of some or all of the information. When a signed request is received by your Authorized Representative, appropriate proof of the designation must be provided.

You can expect a resolution and a written response for all Grievances within 30 calendar days of receipt of your Grievance. If Coordinated Care needs more than 30 days to resolve the Grievance, we will contact you to receive written approval for additional time.

## APPEAL PROCESS

You or your Authorized Representative may file an Appeal when you wish us to reconsider a decision (Adverse Benefit Determination) we made regarding healthcare benefits, services or Claims.

An Adverse Benefit Determination is a decision we made, based on review of information that was provided, to deny, reduce, modify or terminate payment, coverage, Authorization or provision of healthcare services or benefits, including the admission to or continued stay in a healthcare Facility. If we deny a Prior Authorization request, your Provider may Appeal the denial on your behalf without your written consent.

If you have an Appeal about eligibility, your Appeal should be filed with the Washington Health Benefit Exchange. Under federal law, the Exchange is responsible for all eligibility decisions. If your Appeal involves

your eligibility or enrollment, please contact the Exchange at 1-855-923-4633 or visit www.wahbexchange.org.

**How to File an Internal Appeal**
Once you receive or learn of a decision or an Adverse Benefit Determination by us that you would like us to reconsider, you may file an Internal Appeal. Your Internal Appeal will be reviewed by people who were not involved in making the decision you are appealing. Your Internal Appeal may be reviewed as either a Standard Internal Appeal or as an Expedited Internal Appeal. If an immediate decision is required due to your health needs, an Expedited Appeal may be requested.

Appeals can be initiated through either written or verbal request. A Grievance and Appeal Form may be found online at: https://Ambetter.CoordinatedCareHealth.com/resources/handbooks-forms.html. A written request may be faxed to 855-218-0589 or mailed to Coordinated Care at:

Appeal Department
Coordinated Care
1145 Broadway, Suite 300
Tacoma, WA 98402

To request an Appeal by phone, please call Member Services at:
1-877-687-1197 (TTY/ TDD 1-877-941-9238)

An acknowledgement letter will be sent within 72 hours of receipt of the Internal Appeal.

Internal Appeals, including Expedited Appeals, must be pursued within **180 calendar days** of receipt of the original determination. If your request for Appeal is not received within this time period, you will not be able to continue to pursue the Appeal process and may jeopardize your ability to pursue the matter in any forum. If you or your treating Provider determines that your health could be jeopardized by waiting for a decision under the regular Appeal process, you or your Provider may specifically request an Expedited Appeal and a review by an Independent Review Organization concurrently. Please see Expedited Appeals later in this section for more information.

**Internal Appeal Continuation of Care**
If you are still receiving Covered Services that are under Appeal, the services may continue until a decision is made on the Internal Appeal. You should notify us if you are currently receiving services under Appeal, and that you would like to continue those services during the Appeal process. If the final decision in the Appeal process results in a denial, you may be responsible for the costs for services you received during the Appeal process.

**Internal Appeal Review**
The content of the Internal Appeal request including all clinical care aspects involved will be fully reviewed and documented. You or your Authorized Representative will have the right to submit comments, documentation, records, and other information relevant to the Internal Appeal in person or in writing. A Provider or other appropriate clinical peer of a same-or-similar specialty, who was not involved in the initial decision, will evaluate the medical necessity decision of a final determination. You will be given a reasonable opportunity to provide written materials, including written testimony to support your Appeal. Coordinated Care will provide you, or your Authorized Representative, with written notification of our decision:

1. For a non-expedited Internal Appeal, you will be notified within 14 calendar days of receipt of the Appeal.
    a. For good reason, we may extend the time by up to 16 additional calendar days without your or your Authorized Representative's written consent, but will notify you or your Authorized Representative of the extension and reason for the extension. If you or your Authorized Representative agree to our request for further extension, we will provide you or your

Authorized Representative with written notice of a specific agreed-upon date for when we will provide our decision. Waiver of consent to the response time is not required.

2. For Appeals involving an Experimental or Investigational treatment, you will be notified of our decisions within 20 calendar days of receipt of the Appeal.

## EXPEDITED INTERNAL APPEAL

### Expedited Internal Appeal Qualifying Conditions

If your Provider feels that the matter being appealed is urgent due to health needs which cannot wait the standard resolution time, an Expedited Internal Appeal may be requested. Appeals regarding payment for services that have already been provided are not eligible for Expedited Appeals. An Expedited Internal Appeal may be requested if:

1. You are currently receiving or are prescribed treatment for a medical condition; and your treating Provider believes the application of regular Appeal timeframes on a pre-service or concurrent care Claim could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject you to severe and intolerable pain; or
2. The Appeal is regarding an issue related to admission, availability of care, continued stay or healthcare services received on an emergency basis where you have not been discharged.

### Expedited Internal Appeal Submission

An Expedited Internal Appeal is requested in the same manner as a standard Internal Appeal. For an Expedited Internal Appeal your treating Provider may act as your Authorized Representative without a signed written consent from you.

### Expedited Internal Appeal Continuation of Care

If you are currently receiving Covered Services, you may continue to receive services at the expense of Coordinated Care through the completion of the Expedited Internal Appeal process if the Expedited Internal Appeal is filed timely and the service was previously Authorized by Coordinated Care.

### Expedited Internal Appeal Review

The content of the Expedited Internal Appeal request including all clinical care aspects involved will be fully investigated and documented. You or your Authorized Representative will have the right to submit comments, documentation, records, and other information relevant to the Expedited Internal Appeal in person or in writing. A Provider or other appropriate clinical peer of a same-or-similar specialty will evaluate the medical necessity decision of a final determination. The decision will be made as expeditiously as possible for an expedited review request, preferably within 24 hours, but in no case longer than 72 hours from the request for Appeal.

### Appeal Determination Notification

The written notification of resolution of your Appeal will include the specific reasons for the decision. If the Appeal was not decided in your favor, you may request External Review by an Independent Review Organization (IRO). Information for pursuing an External Review will be included in the Appeal Determination letter.

## EXTERNAL REVIEW

### External Review Submission

If you are not satisfied with the final outcome of the Internal Appeal, you may request External Review of the decision by an Independent Review Organization (IRO). This includes, but is not limited to, decisions based on medical necessity, appropriateness, healthcare setting, level of care, or that the requested service or supply is not effective or otherwise unjustified under evidence-based medical criteria. For requests involving Experimental or Investigational treatments, the IRO must ensure that adequate clinical and scientific

experience and protocols are taken into account as part of the External Review process. There is no cost to you for requesting External Review.

You or your Authorized Representative may request External Review or Expedited External Review at the end of the Internal Appeal process. Instructions for submitting the request will be included with the Internal Appeal Determination Notification we send. Expedited External Review can be submitted at the same time the Member submits a request for an Expedited Internal Appeal. You will be provided with at least five business days to submit additional information to the IRO, in writing, that it must consider when conducting the External Review. Within one business day of receiving such additional information, the IRO will forward it to us.

Coordinated Care will work with you and the IRO. The decision made by an IRO is at no cost to you. We will provide the IRO with the denial and Appeal documentation. A written notice of the IRO's decision will be sent to you within 15 days after the IRO receives the necessary information or 20 days after the IRO receives the request.

**External Review Continuation of Care**
If you are still receiving Covered Services that are under External Review, the services may continue until a decision is made on the External Review. You should notify us if you are currently receiving services under External Review, and that you would like to continue those services during the External Review process. If the final decision in the External Review process results in a denial, you may be responsible for the costs for services you received during the External Review process.

**Expedited External Review**
If you disagree with the decision made in the Internal Expedited Appeal and you or your Representative reasonably believe that a pre-service or concurrent care Prior Authorization remains clinically urgent, you may request a voluntary Expedited Appeal to an IRO. The criteria for a voluntary Expedited Appeal to an IRO are the same as described above for non-urgent IRO review. You may request a voluntary Expedited External Appeal at the same time you request an Expedited Appeal from Coordinated Care.

For Expedited External Reviews, the IRO's decision will be provided to you and us as expeditiously as possible after the decision, but no later than within 72 hours of the IRO's receipt of the request. If the initial notice is not in writing, the Independent Review Organization must provide written confirmation of the decision within 48 hours after the date of the notice of the decision.

External Review by an IRO is the final Appeal level. Coordinated Care is bound by the IRO's decision, except to the extent other remedies are available under state or federal law. External Review by an IRO is optional and you should know that other forums may be utilized as the final level of Appeal to resolve a dispute you have with us. This includes but is not limited to civil action under Section 502(a) of ERISA, where applicable.

The U.S. Department of Health and Human Services has designated the Washington State Office of the Insurance Commissioner's Consumer Protection Division as the health insurance consumer ombudsman. The Consumer Protection Division Office can be reached by mail at Washington State Office of the Insurance Commissioner, Consumer Protection Division, P.O. Box 40255, Olympia, WA 98504-0255 or toll free at (800) 562-6900. More information about requesting assistance from the Consumer Protection Division Office can be found at: https://www.insurance.wa.gov/complaints-and-fraud/file-a-complaint/.

**Expedited External Review Continuation of Care**
If you are currently receiving Covered Services, you may continue to receive services at the expense of Coordinated Care through the completion of the Expedited External Review process if the Expedited External Review is filed timely and the service was previously Authorized by Coordinated Care.

**Information**
If you have any questions about the Grievance and Appeal process outlined here, you may contact our Member Services department at 1-877-687-1197 (TTY/ TDD 1-877-941-9238).

# GENERAL PROVISIONS

**Confidentiality**
Each party acknowledges that performance of its obligations under this Contract may involve access to and disclosure of data, procedures, materials, lists, systems and information, including medical records, Member benefits information, Member addresses, social security numbers, e-mail addresses, phone numbers and other confidential information regarding the Member (collectively the "information"). The information shall be kept strictly confidential and shall not be disclosed to any third party other than: (i) Representatives of the receiving party (as permitted by applicable state and federal law) who have a need to know such information in order to perform the services required of such party pursuant to this Contract or for the proper management and administration of the receiving party, provided that such Representatives are informed of the confidentiality provisions of this Contract and agree to abide by them, (ii) pursuant to court order or (iii) to a designated public official or agency pursuant to the requirements of federal, state or local law, statute, rule or regulation. The disclosing party will provide the other party with prompt notice of any request the disclosing party receives to disclose information pursuant to applicable legal requirements, so that the other party may object to the request and/or seek an appropriate protective order against such request. Each party shall maintain the confidentiality of medical records and confidential patient and Member information as required by applicable law.

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

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

**Notices**
Notices provided for in this Contract shall be mailed to us at our principal address and to the Members Residence address as it appears in our records. The Member shall notify us in writing of any changes in Residence within thirty (30) days of such change.

**Compliance with Law**
We and the Member shall comply with all applicable state and federal laws and regulations in performance of this Contract. This Contract is entered into and governed by the laws of Washington State, except as otherwise pre-empted by federal laws.

**Modification of Contract**
This Contract may be modified by us upon thirty (30) days written notice mailed to each Member at their Residence as it appears in our records. Failure to receive such notice shall not affect the modification or Effective Date thereof.

No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this Contract convey or void any coverage, increase or reduce any benefits under this Contract or be used in the prosecution or defense of a claim under this Contract.

**Nondiscrimination**
Coordinated Care does not discriminate on the basis of physical or mental disabilities in its employment practices and services.

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

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

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

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

**Conformity with State Laws**
Any part of this Contract in conflict with the laws of Washington on this Contract's Effective Date or on any premium due date is changed to conform to the minimum requirements of Washington State law.

**List of Available Disclosures**
Have questions? Your Member handbook and this Evidence of Coverage (EOC) have answers. You will be able to find information about benefits, how to access care and important phone numbers. Your materials are located on your online Member account at Ambetter.CoordinatedCareHealth.com.

Upon request, you are entitled to the following:

1. A listing of covered benefits, including Prescription Drug benefits, a copy of the current Formulary, definitions of terms such as generic versus brand name, and policies regarding coverage of drugs, such as how they become approved or taken off the Formulary, and how consumers may be involved in decisions about benefits;
2. A listing of exclusions, reductions, and limitations to covered benefits, and any definition of medical necessity or other coverage criteria upon which they may be based;
3. A statement of our policies for protecting the confidentiality of health information;
4. A statement of the cost of premiums and any enrollee Cost-Sharing requirements;
5. A summary explanation of our review of Adverse Benefit Determinations and Grievance processes;
6. A statement regarding the availability of a point-of-service option, if any, and how the option operates;
7. A convenient means of obtaining lists of participating primary care and specialty care Providers, including disclosure of Network arrangements that restrict access to Providers within any plan Network.

Upon request, you are entitled to the following written information:

1. Any documents or other information referred to in the Evidence of Coverage (EOC);

2. A full description of the procedures to be followed by you for consulting a Provider other than your Primary Care Provider and whether a Prior Authorization is required;
3. Procedures to be followed by you for obtaining Prior Authorization for healthcare services;
4. A written description of any reimbursement or payment arrangements between the issuer and Providers, including capitation provisions, fee-for-service provisions and healthcare delivery efficiency provisions;
5. Descriptions and justifications for Provider compensation programs, including any incentives or penalties that are intended to encourage Providers to withhold services or minimize or avoid Authorizations to Specialists;
6. An annual accounting of payments made by us which have been counted against any payment limitations, visit limitations, or other overall limitations on your coverage under this plan;
7. A copy of our review of Adverse Benefit Determinations Grievance process for Claim or service denial and our Grievance process for dissatisfaction with care;
8. Accreditation status with a NCQA, and information regarding whether we track our healthcare effectiveness performance using Healthcare Effectiveness Data and Information Set (HEDIS), if this information is publicly available and how many people can access HEDIS data.

Upon request, you are also entitled to access:

1. Copies of all documents, records, and other information relevant to a Claim.
2. The criteria, processes, strategies, evidentiary standards and other factors used to make medical necessity determinations of mental health or Substance Use Disorder benefits. This includes information on the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical and mental health or Substance Use Disorder benefits under the health plan.

This list is also available in the Member Resources section at Ambetter.CoordinatedCareHealth.com.

## Statement of Non-Discrimination

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

Ambetter from Coordinated Care:

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

If you need these services, contact Ambetter from Coordinated Care at 1-877-687-1197 (TTY/ TDD 1-877-941-9238).

If you believe that Ambetter from Coordinated Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a Grievance with: Grievances Coordinator Coordinated Care, 1145 Broadway, Suite 300, Tacoma, WA 98402, 1-877-687-1197 (TTY/ TDD 1-877-941-9238), Fax 1-855-218-0588. You can file a Grievance by mail, fax, or email WAqualitydept@centene.com. If you need help filing a Grievance, Ambetter from Coordinated Care is available to help you. You can also file a civil rights Complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

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| **Spanish:** | Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Coordinated Care Corporation, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-687-1197 (TTY/TDD 1-877-941-9238). |
| **Chinese:** | 如果您，或是您正在協助的對象，有關於 Ambetter from Coordinated Care Corporation 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-877-687-1197 (TTY/TDD 1-877-941-9238)。 |
| **Vietnamese:** | Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Coordinated Care Corporation, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-687-1197 (TTY/TDD 1-877-941-9238). |
| **Korean:** | 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Coordinated Care Corporation 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-687-1197 (TTY/TDD 1-877-941-9238)로 전화하십시오. |
| **Russian:** | В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Coordinated Care Corporation вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-877-687-1197 (TTY/TDD 1-877-941-9238). |
| **Tagalog:** | Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Coordinated Care Corporation, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-687-1197 (TTY/TDD 1-877-941-9238). |
| **Ukrainian:** | В разі виникнення у вас або особи, якій ви допомагаєте, будь-яких запитань щодо програми страхування Ambetter from Coordinated Care Corporation ви маєте право отримати безкоштовну допомогу та інформацію на своїй рідній мові. Щоб поговорити з перекладачем, зателефонуйте за номером 1-877-687-1197 (TTY/TDD 1-877-941-9238). |
| **Mon-Khmer, Cambodian:** | ប្រសិនលោកអ្នកឬ នរណាម្នាក់ដែលអ្នកកំពុងតែជួយមានបញ្ហាអំពី Ambetter from Coordinated Care Corporation អ្នកមានសិទ្ធិទទួលបានជំនួយនិងព័ត៌មានជាភាសាលោកអ្នកដោយឥតគិតថ្លៃ។ សូមនិយាយទៅកាន់អ្នកបកប្រែតាមលេខ 1-877-687-1197 (TTY/TDD 1-877-941-9238) |
| **Japanese:** | Ambetter from Coordinated Care Corporation について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-877-687-1197 (TTY/TDD 1-877-941-9238) までお電話ください。 |
| **Amharic:** | እርስዎ ወይም እርሰዎ የሚረዱት ሰው ስለ Ambetter from Coordinated Care Corporation ግብር ጥያቄ ካለዎት ያለምንም ወጪ በቋንቋዎ ድጋፍም እንዲሁም መረጃ የማግኘት መብት አለዎት፤ ፤ እስተርጓሚ ለማነጋገር በ 1-877-687-1197 (TTY/TDD 1-877-941-9238) ይደውሉ፤ ፤ |
| **Cushite:** | Yoo sii ykn namaa gargaaraa jirtuu wa'ee Ambetter from Coordinated Care Corporation (Kuununsaa Qindeeffamaa) irra gaaffi qabaatan ta'ee gargaarsaa fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana wajiin dubadhuu,1-877-687-1197 irra bilbilli (TTY/TDD 1-877-941-9238). |
| **Arabic:** | إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Coordinated Care Corporation، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-687-1197 (TTY/TDD 1-877-941-9238). |
| **Punjabi:** | ਜੇ ਤੁਹਾਡੇ, ਜਾਂ ਤੁਹਾਡੀ ਮਦਦ ਲੈ ਰਹੇ ਕਿਸੇ ਵਿਅਕਤੀ ਦੇ ਮਨ ਵਿਚ Ambetter from Coordinated Care Corporation ਦੇ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮੁਫਤ ਮਦਦ ਲੈਣ ਦਾ ਪੂਰਾ ਹੱਕ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ 1-877-687-1197 (TTY/TDD 1-877-941-9238) 'ਤੇ ਕਾਲ ਕਰੋ। |
| **German:** | Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Coordinated Care Corporation hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-687-1197 (TTY/TDD 1-877-941-9238) an. |
| **Laotian:** | ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ ມີຄໍາຖາມກ່ຽວກັບ Ambetter from Coordinated Care Corporation, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ ໃຫ້ໂທຫາ 1-877-687-1197 (TTY/TDD 1-877-941-9238). |