2020 Evidence of Coverage

Ambetter.ARhealthwellness.com
AMBETTER FROM ARKANSAS HEALTH AND WELLNESS

Home Office: One Allied Drive, Suite 2520, Little Rock, AR, 72202

Major Medical Expense Insurance Policy

In this policy, the terms "you", "your" or "yours" will refer to the covered person enrolled in this policy and "we," "our" or "us" will refer to Ambetter from Arkansas Health & Wellness.

AGREEMENT AND CONSIDERATION

This document along with the corresponding Schedule of Benefits is your policy and it is a legal document. It is the agreement under which benefits will be provided and paid. In consideration of your application and the timely payment of premiums, we will provide benefits to you, the covered person, for covered services as outlined in this policy. Benefits are subject to policy 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 policy (or the new policy 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 policy each year, however, we may decide not to renew the policy as of the renewal date if: (1) we decide not to renew all policy issued on this form, with a new policy 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 (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 policy 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 policy; or (5) a change in federal or state law no longer permits the continued offering of such coverage, such as CMS guidance related to individuals who are Medicare eligible.

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

At least thirty-one (31) days' notice of any plan to take an action or make a change permitted by this clause will be delivered to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under this policy or a change in a covered person's health. While this policy is in force, we will not restrict coverage already in force. Changes to this policy will be approved by the Arkansas Insurance Department.

This policy contains prior authorization requirements. Benefits may be reduced or not covered if the requirements are not met. Please refer to the Schedule of Benefits and the Prior Authorization Section.
You are required to enroll each year in order to receive any subsidies for which you may be eligible.

Celtic Insurance Company

Anand Shukla
SVP, Individual Health

Arkansas Health & Wellness

John Ryan
CEO and Plan President
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INTRODUCTION

Welcome to Ambetter from Arkansas Health & Wellness! We have prepared this policy to help explain your coverage. Please refer to this policy 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 policy, the Schedule of Benefits, the application as submitted to the marketplace and any amendments or riders attached shall constitute the entire contract under which covered services and supplies are provided or paid for by us.

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

How to Contact Us
Arkansas Health & Wellness
Ambetter from Arkansas Health & Wellness
P.O. Box 25408
Little Rock, AR 72221

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. CST, Monday through Friday
Member Services 1-877-617-0390
TDD/TTY line 1-877-617-0392
Fax 1-877-617-0393
Emergency 911
24/7 Nurse Advice Line 1-877-617-0390 or for hearing impaired (TDD/TTY 1-877-617-0392)

Interpreter Services
Ambetter from Arkansas Health & Wellness has a free service to help members who speak languages other than English. These services ensure that you and your provider can talk about your medical or behavioral health concerns in a way that is most comfortable for you. Our interpreter services are provided at no cost to you. We have medical interpreters to assist with languages other than English via phone. An interpreter will not go to a provider's office with you. Members who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation, or to request materials in Braille or large font.

To arrange for interpretation services, please call Member Services at 1-877-617-0390 or for the hearing impaired (TDD/TTY 1-877-617-0392).
MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:
1. Recognizing and respecting you as a member.
2. Encouraging open discussions between you, your physician and medical practitioners.
3. Providing information to help you become an informed 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, or expected health or genetic status.

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.

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

13. A current list of network providers.

14. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.

15. Adequate access to qualified medical practitioners and treatment or services regardless of age, race, sex, sexual orientation, national origin or religion.

16. Access medically necessary urgent and emergency services 24 hours a day and seven days a week.

17. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.

18. Refuse treatment to the extent the law allows. You are responsible for your actions if treatment is refused or if the primary care provider's instructions are not followed. You should discuss all concerns about treatment with your primary care provider. Your primary care provider can discuss different treatment plans with you, if there is more than one plan that may help you. You will make the final decision.

19. Select your primary care provider within the network. You also have the right to change your primary care provider or request information on network providers close to your home or work.

20. Know the name and job title of people giving you care. You also have the right to know which physician is your primary care provider.

21. An interpreter when you do not speak or understand the language of the area.

22. A second opinion by a network provider if you want more information about your treatment or would like to explore additional treatment options.

23. Make advance directives for healthcare decisions. This includes planning treatment before you need it.

24. Advance directives are forms you can complete to protect your rights for medical care. It can help your primary care provider and other providers understand your wishes about your health. Advance directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself. Examples of advance directives include:
   a. Living Will;
   b. HealthCare Power of Attorney; and
   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 policy.
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 provider until you understand the care you are receiving.
4. Review and understand the information you receive about us. You need to know the proper use of covered services.
5. Show your I.D. card and keep scheduled appointments with your provider, and call the provider’s office during office hours whenever possible if you have a delay or cancellation.
6. Know the name of your assigned primary care provider. You should establish a relationship with your physician. You may change your primary care provider verbally or in writing by contacting our Member Services Department.

7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.

8. Understand your health problems and participate, along with your healthcare professionals and physicians in developing mutually agreed upon treatment goals to the degree possible.

9. Supply, to the extent possible, information that we or your 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 primary care provider to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.

12. Follow all health benefit plan guidelines, provisions, policies and procedures.

13. Use any emergency room only when you think you have a medical emergency. For all other care, you should call your primary care provider.

14. Provide all information about any other medical coverage you have upon enrollment in this plan. If, at any time, you get other medical coverage besides this coverage, you must tell the entity with which you enrolled.

15. Pay your monthly premium on time and pay all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service.

16. Inform the entity in which you enrolled for this policy if you have any changes to your name, address, or family members covered under this policy within 60 days from the date of the event.

Health Management Programs Offered
Ambetter from Arkansas Health and Wellness offers the following health management programs:

1. Asthma;
2. Coronary Artery Disease;
3. Diabetes (adult and pediatric);
4. Hypertension;
5. Hyperlipidemia;
6. Low Back Pain; and
7. Tobacco Cessation.

To inquire about these programs or other programs available, you may visit our website at Ambetter.ARHealthWellness.com or by contacting Member Services at 1-877-617-0390.
IMPORTANT INFORMATION

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

At any time, you can request a printed copy of the provider directory at no charge by calling Member Services at 1-877-617-0390. In order to obtain benefits, you must designate a primary care provider for each member. We can help you pick a primary care provider (PCP). We can make your choice of primary care provider effective on the next business day.

Call the primary care provider’s office if you want to make an appointment. If you need help, call Member Services at 1-877-617-0390. We will help you make the appointment.

Member ID Card
When you enroll, we will mail you a member ID card after we receive your completed enrollment materials, and you have paid your initial premium payment. This card is proof that you are enrolled in an Ambetter plan. You need to keep this card with you at all times. Please show this card every time you go for any service under the policy.

The ID card will show your name, member ID# and copayment amounts required at the time of service. If you do not get your ID card within a few weeks after you enroll, please call Member Services at 1-877-617-0390. 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.ARHealthWellness.com. It also gives you information on your benefits and services such as:

1. Finding a network provider.
2. Our programs and services, including programs to help you get and stay healthy.
3. A secure portal for you to check the status of your claims, make payments and obtain a copy of your member ID card.
4. Member Rights and Responsibilities.
5. Notice of Privacy.
6. Current events and news.
7. Our formulary or preferred drug list.
8. Deductible and Copayment Accumulators.
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.

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

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

In this policy, italicized words are defined. Words not italicized will be given their ordinary meaning.

Wherever used in this policy:

Abortion means the use or prescription of any instrument, medicine, drug, or any other substance or device intentionally to terminate the pregnancy of a member known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead unborn child who died as the result of natural causes, accidental trauma, or a criminal assault on the pregnant member or the member’s unborn child.

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 (5) to seven (7) days per week, while the covered person is confined as an inpatient in a hospital, rehabilitation facility, or skilled nursing facility.

Advanced premium tax credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Marketplace. 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 a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

Adverse benefit determination means a determination by us that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet our requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

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

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

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

Ambulatory review means utilization review of healthcare services performed or provided in an outpatient setting.
**Applicable non-English language**, with respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

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

**Authorization or authorized** (also “Prior Authorization” or “Approval”) means our decision to the medically necessity or the appropriateness of care for a member by the member’s PCP or provider group.

**Authorized representative** means an individual who represents you in an internal appeal or external review process of an adverse benefit determination who is any of the following:
1. A person to whom a 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;
3. A family member but only when you are unable to provide consent.

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

**Balance billing** means a non-network provider billing you for the difference between the provider’s charge for a service and the eligible expense. Network providers may not balance bill you for covered expenses.

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

**Billed Amount** is the amount a provider charges for a service.

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

**Care Management** is a program in which a registered nurse, known as a case manager, assists a member through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and healthcare benefits available to a member. Care management is instituted at the sole option of us when mutually agreed to by the member and the member’s physician. Communications made by a physician responsible for the direct care of a member in care management with involved healthcare providers are covered.

**Chiropractic care** is 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 involving urgent care** means any claim for care or treatment with respect to the application of the time periods for making non-urgent care determinations:
1. Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,
2. In the opinion of a physician with knowledge of the claimant's condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment is the subject of the claim.

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

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

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

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

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

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

**Cosmetic treatment** means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an injury, illness, or congenital anomaly.

**Cost sharing** means the deductible amount, copayment amount and coinsurance that you pay for covered services. The cost sharing amount that you are required to pay for each type of covered service is listed in the Schedule of Benefits.

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

Covered expense or covered service means an expense or service that is:
1. Incurred while your or your dependent’s insurance is in force under this policy;
2. Covered by a specific benefit provision of this policy; and
3. Not excluded anywhere in this policy.

Covered person means you, your lawful spouse and each eligible child:
1. Named in the application; or
2. Whom we agree in writing to add as a covered person.

Craniofacial anomaly means a congenital or acquired musculoskeletal disorder that primarily affects the cranial facial tissue.

Craniofacial corrective surgery means the use of surgery to alter the form and function of the cranial facial tissues due to a congenital or acquired musculoskeletal disorder.

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

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

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

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

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

If you are a covered member in a family of two or more members, you will satisfy your deductible amount when:
1. You satisfy your individual deductible amount; or
2. Your family satisfies the family deductible amount for the calendar year.

If you satisfy your individual deductible amount, each of the other members of your family are still responsible for the deductible until the family deductible amount is satisfied for the calendar year.
**Dental expenses** means *surgery* or services provided to diagnose, prevent, or correct any ailments or defects of the teeth and supporting tissue and any related supplies or oral appliances. Expenses for such treatment are considered *dental expenses* regardless of the reason for the services.

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

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

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

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

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

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

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

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

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

   b. When a covered expense (excluding Transplant Benefits) is received from a non-network provider as approved or authorized by us that is not the result of an emergency, or because the service or supply is not of a type provided by any network provider, the eligible expense is the lesser of (1) the negotiated fee, if any, that has been mutually agreed upon by us and the provider; or (2) the amount reasonably accepted by the provider (not to exceed the provider’s charge).

   c. Except as provided under (2)(a) and (2)(b) above, when a covered expense (excluding Transplant Benefits) is received from a non-network provider, the eligible expense is determined based on the lowest amount of the following:
      i. the negotiated fee that has been agreed upon by us and the provider;
ii. 100% of the fee Medicare allows for the same or similar services provided in the same geographical area;

iii. the fee established by us by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by us;

iv. the fee charged by the provider for the services; or

v. a fee schedule that we develop.

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

3. Transplant benefits are covered as an eligible expense when received by a network provider or by a non-network provider, when authorized by us.

**Emergency** means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain which requires immediate (no later than 48 hours after onset) medical or surgical care and such that an average person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the covered person or, with respect to a 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 the following:

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

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

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

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

1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the claimant or the ability of the claimant to regain maximum function;

2. In the opinion of a provider with knowledge of the claimant’s medical condition, the claimant is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance; and

3. A provider with knowledge of the claimant’s medical condition determines that the grievance shall be treated as an expedited grievance.

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

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

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

4. Experimental or investigational according to the provider’s research protocols.

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

Final adverse benefit determination means an adverse benefit determination that is upheld at the completion of a health plan issuer's internal appeals process.

Gastric pacemaker means a medical device that uses an external programmer and implanted electrical leads to the stomach; and transmits low-frequency, high-energy electrical stimulation to the stomach to entrain and pace the gastric slow waves to treat gastroparesis.

Gastroparesis means a neuromuscular stomach disorder in which food empties from the stomach more slowly than normal.

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 expense under the policy. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by us.

Grievance means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing in any form to the insurer by, or on behalf of, a claimant including any of the following:

1. Provision of services;
2. Determination to rescind a policy;
3. Determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders; and
**Habilitative or Habilitation Services** means services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition. These services may include physical, occupational and speech therapies, developmental services and *durable medical equipment* for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder.

**Habilitative Developmental Services** means providing instructions in the areas of self-help, socialization, communication, cognition, and social/ emotional skills. Examples include, but are not limited to, toileting, dressing, using fine motor skills, crawling, walking, categorization, expressing oneself (making wants and needs known), picture recognition, identifying letters, numbers, shapes, etc., appropriate play skills and coping mechanisms.

**Healthcare provider or provider** means a health care professional or facility.

**Healthcare professional** means a *physician*, psychologist, nurse practitioner, or other healthcare practitioner licensed, accredited, or certified to perform healthcare services consistent with state law.

**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 covered person.

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

**Home healthcare agency** means a public or private agency, 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*.

**Hospice** means services designed for and provided to members who are not expected to live for more than 6 months, as certified by an Ambetter physician. Ambetter works with certified hospice programs licensed by the state to minimize patient discomfort and address the special physical, psychological, and social needs of a *terminally ill covered person* and those of the covered person’s immediate family.

**Hospital** means an institution that:
1. Operates as a *hospital* pursuant to law;
2. Operates primarily for the reception, care, and treatment of sick or injured persons as *inpatients*;
3. Provides 24-hour nursing service by registered nurses on duty or call;
4. Has staff of one or more *physicians* available at all times;
5. Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or in facilities available to it on a prearranged basis; and
6. Is not primarily a long-term care facility; a *skilled nursing 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, skilled nursing 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 covered person will be deemed not to be confined in a hospital for purposes of this policy.

**Illness** means a sickness, disease, or disorder of a covered person.

**Immediate family** means the parents, spouse, eligible child, or siblings of any covered person, or any person residing with a covered person.

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

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

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

**Intensive care unit** means a unit or area of a hospital that meets the required standards of the Joint Commission.

**Intensive day rehabilitation** means two or more different types of therapy provided by one or more rehabilitation licensed practitioners and performed for three (3) or more hours per day, five (5) to seven (7) days per week.

**Language assistance** means translation services provided if requested. Contact customer service at 1-877-617-0390 if oral or written services are needed.

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

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

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

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

Maximum out-of-pocket amount is the sum of the deductible amount, prescription drug deductible amount (if applicable), copayment amount and coinsurance percentage of covered services, as shown in the Schedule of Benefits. Please note: There are separate maximum out-of-pocket amounts for in network benefits versus out of network benefits.

After the maximum out-of-pocket amount is met for an individual, Ambetter pays 100% of eligible expenses for that individual. The family maximum out-of-pocket amount is two times the individual maximum out-of-pocket amount. Both the individual and the family maximum out-of-pocket amounts are shown in the Schedule of Benefits (in network and out of network).

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

If you are a covered member in a family of two or more members, you will satisfy your maximum out-of-pocket when:
1. You satisfy your individual maximum out-of-pocket; or
2. Your family satisfies the family maximum out-of-pocket amount for the calendar year.

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

Maximum therapeutic benefit means the point in the course of treatment where no further improvement in a covered person's medical condition can be expected, even though there may be fluctuations in levels of pain and function.
**Medical care** means the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body and for transportation primarily for and essential to the provision of such care.

**Medical foods** means low-protein modified food products, amino-acid-based elemental formulas, extensively hydrolyzed protein formulas, formulas with modified vitamin or mineral content and modified nutrient content formulas.

**Medical practitioner** includes, but is not limited to, a physician, nurse anesthetist, physician's assistant, physical therapist, licensed mental health and substance use practitioners, nurse practitioners, audiologists, chiropractors, dentists, pharmacists, nurse anesthetists, optometrists, podiatrists, psychologists or midwife. The following are examples of providers that are NOT medical practitioners, by definition of the policy: acupuncturist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, emergency medical technician, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a covered person, a medical practitioner must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

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

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

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

**Medicare opt-out practitioner** means a medical practitioner who:

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

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

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

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

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

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

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

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

**Network provider** means a medical practitioner or provider who is contracted to provide covered services. The most current published list for the network can be found at Ambetter.ARHealthWellness.com.

**Neurologic Rehabilitation Facility** means an institution licensed as such by the appropriate state agency. A neurological rehabilitation facility must:
1. be operated pursuant to law;
2. be accredited by the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities;
3. be primarily engaged in providing, in addition to room and board accommodations, rehabilitation services for severe traumatic brain injury under the supervision of a duly licensed physician; and
4. maintain a daily progress record for each patient.

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

**Non-network provider** means a medical practitioner who is not contracted with the plan as a participating provider. Services received from a non-network provider are covered at a reduced amount from those services received from a network provider. Please refer to your Schedule of Benefits.

**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. Orthotic devices must be used for therapeutic support, protection, restoration or function of an impaired body part for treatment of an illness or injury.

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

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

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

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

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

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

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

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

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

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

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

Primary care provider means a provider who gives or directs health care services for you. Primary care providers includes a family practitioner, general practitioner, advanced practice registered nurses (APRN), physician assistant (PA), pediatrician, internist, obstetrician, gynecologist, or any other practice allowed under the policy. A primary care provider supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

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

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

Prosthetic device means a medically necessary device used for replace, correct, or support a missing portion of the body, to prevent or correct a physical deformity or malfunction, or to support a weak or deformed portion of the body.
**Provider facility** means a hospital, rehabilitation facility, or skilled nursing facility.

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

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

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

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

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

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

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

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

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

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

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

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

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

**Respite care** means home healthcare services provided temporarily to a covered person in order to provide relief to the covered person’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 Arkansas to sell and market our health plans. This is where the majority of our network providers are located where you will receive all of your health care services and supplies.

**Severe Traumatic Brain Injury** means a sudden trauma causing damage to the brain as a result of the head suddenly and violently hitting an object or an object piercing the skull and entering brain tissue with an extended period of unconsciousness or amnesia after the injury or a Glasgow Coma Scale below 9 within the first 48 hours of injury.

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

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

**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** means a physician 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.

**Stabilize**, as used when referring to an emergency, means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of an individual’s medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:
1. Placing the health of the individual or, with respect to a pregnant member, the health of the member or the member’s unborn child, in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;

And in the case of a member having contractions, “stabilize” means such medical treatment as may be necessary to deliver, including the placenta.

**Sub-acute rehabilitation** means one or more different types of therapy provided by one or more rehabilitation licensed practitioners and performed for one-half (1/2) hour to two (2) hours per day, five (5) to seven (7) days per week, while the covered person is confined as an inpatient in a hospital, rehabilitation facility, or skilled nursing facility.
**Substance use** or **substance use disorder** means alcohol, drug or chemical abuse, overuse, or dependency. Covered **substance use disorders** are those listed in the most recent edition of the International Statistical Classification of Diseases and Related Health Problems or the most current edition of the Diagnostic and Statistical Manual of Mental Disorders.

**Surgery** or **surgical procedure** means:
1. An invasive diagnostic procedure; or
2. The treatment of a covered person’s illness or injury by manual or instrumental operations, performed by a provider while the covered person is under general or local anesthesia.

**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.

**Surveillance tests for ovarian cancer** means annual screening using:
1. CA-125 serum tumor marker testing;
2. Transvaginal ultrasound; or
3. Pelvic examination.

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

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

**Terminally ill** means a physician has given a prognosis that a covered person has six (6) months or less to live.

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

**Tobacco use** or **use of tobacco** means use of tobacco by individuals who may legally use tobacco under federal and state law on average four or more times per week and within the six months immediately preceding the date application for this policy was completed by the covered person, including all tobacco products but excluding religious and ceremonial uses of tobacco.
Transcranial Magnetic Stimulation (TMS) means 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.

Transfer has the same meaning as in section 1867 of the “Social Security Act,” 49 Stat. 620 (1935), 42 U.S.C.A. 1395dd, as amended.

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

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

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

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

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

Dependent Eligibility
Your dependents become eligible for insurance on the latter of:
1. The date you became covered under this policy; or
2. The date of marriage to add a spouse; or
3. The date of an eligible newborns birth; or
4. The date that an adopted child is placed with you or your spouse for the purposes of adoption or you or your spouse assumes total or partial financial support of the child.

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

Coverage for a Newborn Child
An eligible child born to a covered person will be covered from the time of birth provided that (1) notice of the newborn is given to us by the Marketplace within ninety (90) days from birth, and premium billed for this 90-day period, is timely paid under the terms of this policy and its grace period after such notice. The newborn child will be covered from the time of its birth until the 91st day after its birth. Covered expense shall also include routine nursery care and pediatric charges for a well newborn child for up to five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time. Each type of covered service incurred by the newborn child will be subject to the cost sharing amount listed in the Schedule of Benefits.

If notice is not provided within ninety (90) days after birth, or premium for such ninety (90) day period is not timely paid after such notice under the terms of this policy and its grace period, coverage for the newborn will not be effective and the newborn cannot be enrolled until the next open enrollment period.

Coverage for an Adopted Child
An adopted child of a covered person shall be covered from the date of the filing of a petition for adoption if (1) the covered person applies for coverage within sixty (60) days after the filing of the petition for adoption and where the issuer is notified by the Marketplace and (2) premium billed for this 60-day period is timely paid under the terms of this policy and its grace period after such application. However, the coverage shall begin from the moment of birth if (1) the petition for adoption and application for coverage is filed within sixty (60) days after the birth of the child, and (2) premium billed for this 60-day period is timely paid under the terms of this policy and its grace period after such application. 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.

Unless an application is received within 60 days of petition of adoption, and premium is timely paid for the first 60 days under the terms of this policy and its grace period, coverage for the adopted child will not be effective and the adopted child cannot be enrolled until the next open enrollment period. Coverage for an adopted child shall terminate upon the dismissal or denial of a petition for adoption.

As used in this provision, "placement" means the earlier of:
1. The date that you or your spouse assume physical custody of the child for the purpose of adoption; or
2. The date of entry of an order granting you or your spouse custody of the child for the purpose of adoption.
**Adding Other Dependent Members**
If you are enrolled in an off-exchange policy and apply in writing to add a dependent and you pay the required premiums, we will send you written confirmation of the added dependent's effective date of coverage and ID cards for the added dependent.

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

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 Ambetter allowable and you may be billed for any balance of costs above the Ambetter allowable.
ONGOING ELIGIBILITY

For All Covered Persons
A covered person's eligibility for insurance under this policy will cease on the earlier of:
1. The date that a covered person has failed to pay premiums or contributions in accordance with the terms of this policy or the date that we have not received timely premium payments in accordance with the terms of this policy; or
2. The date the member has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or
3. The date of termination that the Marketplace provides us upon your request of cancellation to the Marketplace, or if you enrolled directly with us, the date we receive a request from you to terminate this contract, or any later date stated in your request; or
4. The date we decline to renew this policy, as stated in the Discontinuance provision; or
5. The date of a covered person's death; or
6. The date a covered person's eligibility for insurance under this policy ceases due to losing network access as the result of a permanent move.

For Dependent Members
A dependent will cease to be a covered person at the end of the premium period in which the covered person ceases to be your dependent due to divorce or if a child ceases to be an eligible child. For eligible children, the Marketplace will send a termination letter with an effective date the last day of the dependent’s 26th birth month.

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

A covered person will not cease to be a dependent eligible child solely because of age if the eligible child is:
1. Not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit was reached; and
2. Mainly dependent on you for support.

The policyholder must provide notification and proof of the incapacity or dependency to us at our request and expense.

There is no time limit for the policyholder to provide notification that their incapacitated dependent has reached the age limit.

If you have material modifications (examples include a change in life event such as marriage, death or other change in family status), or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Marketplace) at www.healthcare.gov or 1-800-318-2596. If you enrolled through Ambetter contact Member Services Department at 1-877-617-0390 or TDD/TTY 1-877-617-0392.

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

Special Enrollment
A qualified individual has sixty (60) days to report a qualifying event to the Marketplace and could be granted a 60 day Special Enrollment Period as a result of one of the following events:
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 member's unborn child, or medically needed coverage;

A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or 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 one or more days during the 60 days preceding the date of marriage;

An individual who was not previously a citizen, national, or lawfully present individual gains such status;

An individual who is no longer incarcerated or whose incarceration is pending the disposition of charges;

A qualified individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Marketplace or HHS, or its instrumentalities as evaluated and determined by the Marketplace. In such cases, the Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or agent;

An enrollee adequately demonstrates to the Marketplace that the qualified health plan in which the covered person is enrolled substantially 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;

An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan;

A qualified individual or enrollee gains access to new qualified health plans as a result of a permanent move;

Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;

  a. The qualifying events for employees are:
     i. Voluntary or involuntary termination of employment for reasons other than gross misconduct; or
     ii. Reduction in the number of hours of employment
  b. The qualifying events for spouses are:
     i. Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct;
     ii. Reduction in the hours worked by the covered employee;
     iii. Covered employee's becoming entitled to Medicare;
     iv. Divorce or legal separation of the covered employee; or
     v. Death of the covered employee.
  c. The qualifying events for dependent children are the same as for the spouse with one addition:
     i. Loss of dependent child status under the plan rules.

Note: The employee would not qualify for a special enrollment period if any of the criteria above has not been met.

An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month; or

A qualified individual or enrollee demonstrates to the Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Marketplace may provide.
• 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;
• 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
• At the option of the Health Insurance Marketplace, 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 Health Insurance Marketplace following termination of Marketplace 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.

In the case of marriage, or in the case where qualified individual loses minimum essential coverage, the effective date is the first day of the following month.

The Marketplace may provide a coverage effective date for a qualified individual earlier than specified in the paragraphs above, provided that either:
   1. The qualified individual has not been determined eligible for advance payments of the premium tax credit or cost-sharing reductions; or
   2. The qualified individual pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of advance payments of the premium tax credit and cost-sharing reduction payments until the first of the next month.
PREMIUMS

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

Grace Period
When a member is receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due before the first day of each month for coverage effective during such month. After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. 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 advanced premium tax credits are received.

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

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

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

1. Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
2. Indian tribes, tribal organizations or urban Indian organizations;
3. State and Federal Government programs;
4. Family members; or
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**.

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

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 **covered person's** age has been misstated, the **member's** premium may be adjusted to what it should have been based on the **member's** actual age.

**Change or Misstatement of Residence**
If you change your residence, you must notify the Marketplace of your new residence within sixty (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 **covered person's** answer to the tobacco question listed on the **covered person's** application for coverage is material to our determination of premium. If a **covered person's use of tobacco** has been misstated on the covered person's application for coverage under this policy, we have the right to charge corrected premiums for the policy back to the original **effective date**.
COST SHARING FEATURES

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

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

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

Coinsurance 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. When the annual out-of-pocket maximum has been met, additional covered services will be 100%.

Deductible
The deductible amount means the amount of eligible expenses that must be paid by all covered persons before any benefits are payable. The deductible amount does not include any copayment amount or coinsurance amount. Not all eligible expenses are subject to the deductible amount. See your Schedule of Benefits for more details.

The amount payable will be subject to:
1. Any specific benefit limits stated in the policy;
2. A determination of eligible expenses; and
3. Any reduction for expenses incurred at a non-network provider. Please refer to the information on the Schedule of Benefits.

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

Note: The bill you receive for services or supplies from a non-network provider may be significantly higher than the eligible expenses for those services or supplies. In addition to the deductible amount, copayment amount, and coinsurance percentage, you are responsible for the difference between the eligible 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 expense will not apply to your deductible amount or maximum out-of-pocket.
ACCESS TO CARE

Primary Care Provider
You may select any network primary care provider who is accepting new patients. You may obtain a list of network primary care providers at our website or by contacting our Member Services department.

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

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

Service Area
Arkansas Health & Wellness operates in a service area which covers the entire state. If you move from one county to another within the service area your premium may change. Please refer to the Premium section for more information. If you move out of Arkansas, you are no longer eligible for coverage under this policy and may be eligible for enrollment into another qualified health plan during a special enrollment period.

Coverage Under Other Policy Provisions
Charges for services and supplies that qualify as covered expenses under one benefit provision will not qualify as covered expenses under any other benefit provision of this policy.
MAJOR MEDICAL EXPENSE BENEFITS

This policy provides coverage for healthcare services for members and dependents. Some services require prior authorization. Copayment amounts must be paid to your network provider at the time services are rendered. Covered services are subject to all policy provisions, including conditions, terms, limitations and exclusions. Covered services must be medically necessary and not experimental or investigational.

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

Ambulance Service Benefits
Covered expenses will include ground, air or water ambulance services for local transportation:

1. To the nearest hospital that can provide services appropriate to the covered person’s illness or injury, in cases of emergency; or
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; or
3. Transportation between hospitals or between a hospital and skilled nursing or rehabilitation facility when authorized by Ambetter.

Benefits for air ambulance services are limited to:

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

Exclusions:
No benefits will be paid for:

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

Chelation Therapy
Covered expenses for chelation therapy for control of ventricular arrhythmias or heart block associated with digitalis toxicity, emergency treatment of hypercalcemia, extreme conditions of metal toxicity, including thalassemia intermedia with hemosiderosis, Wilson’s disease (hepatolenticular degeneration), lead poisoning and hemochromatosis is covered.

Chiropractic Services
Chiropractic services are covered when a chiropractor finds services are medically necessary to treat or diagnose neuromusculoskeletal disorders on an outpatient basis. Covered service expenses are subject to all other terms and conditions of the policy, including deductible amount and cost sharing percentage provisions.
Craniofacial Corrective Surgery and Related Expenses
Covered expenses shall include craniofacial corrective surgery and related medical care for a person of any age who is diagnosed as having a craniofacial anomaly, provided that the surgery and treatment are medically necessary to improve a functional impairment that results from the craniofacial anomaly as determined by the American Cleft Palate-Craniofacial Association in Chapel Hill, North Carolina.

A nationally accredited cleft-craniofacial team for cleft-craniofacial conditions shall:
1. Evaluate a covered persons with craniofacial anomalies; and
2. Coordinate a treatment plan for each person.

Covered expenses may include medically necessary dental care, vision care, and the use of at least one (1) hearing aid, if related to the craniofacial corrective surgery and included in the treatment plan described above.

Durable Medical Equipment (DME), Prosthetics, and Orthotic Devices
The supplies, equipment and appliances described below are covered services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is medically necessary in your situation or needed to treat your condition, reimbursement will be based on the maximum allowable amount for a standard item that is a covered service, serves the same purpose, and is medically necessary. Any expense that exceeds the maximum allowable amount for the standard item which is a covered service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition. Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:
1. The equipment, supply or appliance is a covered service;
2. The continued use of the item is medically necessary; and
3. There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

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

Benefits for repairs and replacement do not include the following:
1. Repair and replacement due to misuse, malicious breakage or gross neglect.
2. Replacement of lost or stolen items.

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

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

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

**Medical and surgical supplies**
Coverage for non-durable medical supplies and equipment for management of disease and treatment of medical and surgical conditions.

**Covered services** may include, but are not limited to:
1. Allergy serum extracts.
2. Chem strips, glucometer, lancets.
3. Clinitest.
5. Ostomy bags and supplies except charges such as those made by a pharmacy for purposes of a fitting are not covered services.

Exclusions:
Non Covered Services include but are not limited to:
1. Adhesive tape, band aids, cotton tipped applicators.
2. Arch supports.
3. Doughnut cushions.
4. Hot packs, ice bags.
5. Vitamins (except as provided for under Preventive benefits).
7. Items usually stocked in the home for general use like band aids, thermometers, and petroleum jelly.

**Prosthetics**

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

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

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

*Covered services* may include, but are not limited to:

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

**Exclusions:**

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

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

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**Member Services Department**: 1-877-617-0390 (TDD/TTY 1-877-617-0392)

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

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

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

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

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

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

Diabetic Supplies: including insulin syringes, lancets, urine testing reagents, blood glucose monitoring reagents and insulin.

Electrotherapy stimulators
Covered expenses include using Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication. Coverage is also provided for Neuromuscular Electrical Stimulation (NMES) for treatment of disuse atrophy where nerve supply to the muscle is intact, including but not limited to atrophy secondary to prolonged splinting or casting of the affected extremity, contracture due to scarring of soft tissue, as in burn lesions and hip replacement surgery, until orthotic training begins.

Enteral Feedings
Coverage for enteral feedings when such have been approved and documented by a provider as being the member's sole source of nutrition. Enteral feedings require prior authorization by care management.

Contraception
All FDA-approved contraception methods (identified on www.fda.gov) are approved for members without cost sharing as required under the Affordable Care Act. Members have access to the methods available and outlined on our Drug Formulary or Preferred Drug List without cost share. 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. This benefit contains both pharmaceutical and medical methods, including:

1. Intrauterine devices (IUD), including insertion and removal;
2. Barrier methods including: male and female condoms (Rx required from provider, limited to 30 per month), diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide and spermicide alone;
3. Oral contraceptives including the pill (combined pill and extended/continuous use), and the mini pill (Progestin only), patch;
4. Other hormonal contraceptives, including inserted and implanted contraceptive devices, hormone contraceptive injections and the vaginal contraceptive ring;
5. Emergency contraception (the morning after pill);
6. Prescription based sterilization procedures for women; and
7. FDA-approved tubal ligation.

Diabetes Care
For medically necessary services and supplies used in the treatment of diabetes. Covered expenses include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine or ketone strips, blood glucose monitor supplies, glucose strips for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication; and one retinopathy examination screening per year.

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

Covered 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; and
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 a dialysis facility we designate, we 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.

High Frequency Chest Wall Oscillators
Covered expenses for a member with cystic fibrosis, is provided for one high frequency chest wall oscillator during such member’s lifetime.
Inotropic Agents for Congestive Heart Failure
Covered expenses for infusion of inotropic agents where the member is on a cardiac transplant list at a hospital where there is an ongoing cardiac transplantation program.

Mental Health and Substance Use Disorder Benefits

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

Our behavioral health vendor oversees the delivery of covered behavioral health and substance use disorder services for Arkansas Health & Wellness. Mental health services will be provided on an inpatient and outpatient basis and include treatable mental health conditions. These conditions affect the member’s ability to cope with the requirements of daily living. If you need mental health or substance use disorder treatment, you may choose a provider participating in our behavioral health network. Deductible amounts, copayment or coinsurance amounts and treatment limits for covered mental health and substance use disorder benefits will be applied in the same manner as physical health service benefits.

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

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

Covered inpatient and outpatient mental health 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 abuse; 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, group therapy, and marriage counseling 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 disorders;
11. Telemedicine; and
12. Electroconvulsive Therapy (ECT).
13. Transcranial Magnetic Stimulation (TMS)

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

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

**Autism Spectrum Disorder Benefits**
Generally recognized services prescribed in relation to autism spectrum disorder by a physician or behavioral health practitioner in a treatment plan recommended by that physician or behavioral health practitioner.

For purposes of this section, generally recognized services may include services such as:
- evaluation and assessment services;
- applied behavior analysis;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; or
- Habilitation services, limited to children ages 0 to 21 with a diagnosis of autism spectrum disorder; or
- medications or nutritional supplements used to address symptoms of autism spectrum disorder.

No limitation exists within the benefits for applied behavior analysis services. These services are subject to prior authorization to determine medical necessity.

Applied behavior analysis has the following service minimums:
- Applied Behavioral Analysis Treatment Plan: Three hours every three months;
- Applied Behavioral Analysis Testing: Three hours every three months;
- Applied Behavioral Analysis Supervision: Six hours per week for 50 weeks;
- Applied Behavioral Analysis Direct Line Service: 24 hours per week for 50 weeks.

**Rehabilitation Expense Benefits**
Covered expenses include expenses incurred for rehabilitation services, subject to the following limitations:
1. Covered expenses available to a covered person while confined primarily to receive rehabilitation are limited to those specified in this provision;
2. Rehabilitation services or confinement in a rehabilitation facility must begin within 14 days of a hospital stay of at least 3 consecutive days and be for treatment of, or rehabilitation related to, the same illness or injury that resulted in the hospital stay;
3. Covered expenses for provider facility services are limited to charges made by a hospital or rehabilitation facility for:
   a. Daily room and board and nursing services;
   b. Diagnostic testing; and
c. Drugs and medicines that are prescribed by a physician, filled by a licensed pharmacist and approved by the U.S. Food and Drug Administration; and

4. Covered expenses for non-provider facility services are limited to charges incurred for the professional services of rehabilitation licensed practitioners;

5. Outpatient physical therapy, occupational therapy, speech therapy and aural therapy for rehabilitative purposes;

6. Inpatient physical therapy, occupational therapy, speech therapy and aural therapy for rehabilitative purposes; and

7. Cardiac rehabilitation, limited to 36 visits per member per year.

Outpatient physical therapy, speech therapy, occupation therapy and chiropractic care are limited to 30 days per covered person per year. Inpatient physical therapy, speech therapy and occupation therapy are limited to 60 days per covered person per year. See the Schedule of Benefits for benefit levels or additional limits.

Care ceases to be rehabilitation upon our determination of any of the following:
1. The covered person has reached maximum therapeutic benefit;
2. Further treatment cannot restore bodily function beyond the level the covered person already possesses;
3. There is no measurable progress toward documented goals; and
4. Care is primarily custodial care.

Neurological Rehabilitation Facility Services
Covered expenses for neurologic rehabilitation facility services are limited to:
1. The member must be suffering from severe traumatic brain injury;
2. The admission must be within 7 days of release from a hospital;
3. Prior authorization must be given with written approval of the admission to the neurologic rehabilitation facility prior to the member receiving neurologic rehabilitation facility services; and
4. The neurologic rehabilitation facility services are of a temporary nature with a potential to increase ability to function.

Exclusions and Limitations:
No benefits will be paid under this benefit subsection for expenses incurred:
1. Custodial care is not covered; and
2. Coverage is provided for a maximum of 60 days per member per lifetime.

Skilled Nursing Facility Expense Benefits
Covered expenses include expenses incurred for services or confinement in a skilled nursing facility, subject to the following limitations:
1. Services or confinement in a skilled nursing facility must begin within 14 days of a hospital stay of at least 3 consecutive days and be for treatment of, the same illness or injury that resulted in the hospital stay;
2. Covered expenses for provider facility services are limited to charges made by a hospital or skilled nursing facility for:
   a. Daily room and board and nursing services;
   b. Diagnostic testing; and
   c. Drugs and medicines that are prescribed by a physician, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.

Skilled Nursing Facility charges are limited to 60 days per covered person per year. See the Schedule of Benefits for benefit levels or additional limits.
Habilitation Expense Benefits

Covered expenses include expenses incurred for habilitation services, subject to the following limitations:

1. Covered expenses for habilitation services, including physical, occupational and speech therapies, developmental services and durable medical equipment for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder; and
2. The habilitation services must be received on an outpatient basis.

Outpatient physical therapy, speech therapy and occupation therapy are limited to 30 days per covered person per year. Inpatient physical therapy, speech therapy and occupation therapy are listed to 60 days per covered person per year. See the Schedule of Benefits for benefit levels or additional limits. Please note there are separate limits for developmental services provided as part of the habilitation benefits listed above.

Habilitation Developmental Services are limited to 180 visits per member per year. Examples include, but are not limited to, toileting, dressing, using fine motor skills, crawling, walking, categorization, expressing oneself (making wants and needs known), picture recognition, identifying letters, numbers, shapes, etc., appropriate play skills and coping mechanisms.

Home Health Care Expense Benefits

Covered expenses for home health care are covered when your physician indicates you are not able to travel for appointments to a medical office. Coverage is provided for medically necessary in-network care provided at the member’s home and are limited to the following charges:

1. Home health aide services;
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for home healthcare and developmental services associated with developmental delays, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder;
3. I.V. medication and pain medication (I.V. medication and pain medication are covered service expenses to the extent they would have been covered service expenses during an inpatient hospital stay);
4. Hemodialysis, and for the processing and administration of blood or blood components;
5. Necessary medical supplies;
6. Rental of medically necessary durable medical equipment at the discretion of the plan. At our option, we may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider we authorize before the purchase; and
7. Sleep studies.

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.

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

Limitations:

Covered expenses for home health aide services will be limited to:

1. Seven visits per week; and
2. A calendar year maximum of fifty (50) visits.

Each eight-hour period of home health aide services will be counted as one visit.
Exclusion:
No benefits will be payable for charges related to custodial care, or educational care, under the Home Healthcare Service Expense Benefit.

Hospice Care Expense Benefits
Hospice care benefits are allowable for a terminally ill covered person receiving medically necessary care under a hospice care program.

The list of covered expenses in the Medical and Surgical Expense Benefits provision is expanded to include:
1. Room and board in a hospice while the covered person is an inpatient;
2. Occupational therapy;
3. Speech-language therapy;
4. The rental of medical equipment while the terminally ill covered person is in a hospice care program to the extent that these items would have been covered under the policy if the covered person had been confined in a hospital;
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management;
6. Counseling the covered person regarding the covered person’s terminal illness;
7. Terminal illness counseling of members of the covered person’s immediate family; and
8. Bereavement counseling.

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

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

Respite Care Expense Benefits
Respite care is covered on an inpatient, home, or outpatient basis to allow temporary relief to family members from the duties of caring for a covered person under hospice care. Respite days that are applied toward the deductible are considered benefits provided and shall apply against any maximum benefit limit for these services. Coverage is limited to 14 days per year.

Hospital Benefits
Covered expenses are limited to charges made by a hospital for:
1. Daily room and board.
   a. Hospital admissions are subject to pre-admission notification. Please call the number listed on your identification card to notify us of the admission.
   b. Services rendered in a hospital in a country outside of the United States of America shall not be paid except at our sole discretion;
   c. Admissions to a long term acute care hospital or to a long term acute care division of a hospital are subject to pre-admission notification.
2. Daily room and board and nursing services while confined in an intensive care unit.
3. Inpatient use of an operating, treatment, or recovery room;
4. Outpatient use of an operating, treatment, or recovery room for surgery;
5. Services and supplies, including drugs and medicines, that are routinely provided by the hospital to persons for use only while they are inpatients;

6. For a condition requiring that you be isolated from other patients, we will pay for an isolation unit equipped and staffed as such; and

7. Emergency treatment of an injury or illness, even if confinement is not required. When emergency treatment is needed the covered person should seek care at the nearest facility. Emergency treatment received within forty-eight (48) hours of the emergency is subject to the deductible, copayment and coinsurance specified in the Schedule of Benefits. If the covered person is admitted as an inpatient to the same hospital where emergency treatment was rendered, the emergency treatment copayment is waived and all services are subject to the inpatient deductible, copayment and coinsurance.

   a. After-Hours Clinic or Urgent Care Center. Services provided in an after-hours urgent care center are subject to the urgent care deductible, copayment and coinsurance for each visit.

   b. Observation Services. Observation services are covered when ordered by a physician.

   c. Transfer to Network Hospital. Continuing or follow-up treatment for injury or emergency treatment is limited to care that meets primary coverage criteria before you can be safely transferred, without medically harmful or injurious consequences, to a network hospital in the service area. Services are subject to all applicable deductible, copayment and coinsurance.

   d. Emergency Hospital Admissions. You are responsible for notifying Arkansas Health & Wellness of an emergency admission to a hospital within 24 hours or the next business day. Failure to notify Arkansas Health & Wellness may result in the covered person paying a greater portion of the medical bill.

   e. Medical Review of Emergency Care. Emergency treatment is subject to medical review. If, based upon the signs and symptoms presented at the time of treatment as documented by attending healthcare personnel, Arkansas Health & Wellness determines that a visit to the emergency room fails to meet the definition of emergency treatment, coverage shall be denied and the emergency room charges will become the covered person’s responsibility.

8. Services of a social worker while hospitalized.

**In Vitro Fertilization**

Benefits for in vitro fertilization procedures are covered when:

1. The patient is the policyholder or the spouse of the policyholder and a covered dependent under the policy, and the covered person’s oocytes are fertilized with the sperm of the patient’s spouse, and the patient and the patient’s spouse have a history of unexplained infertility of at least two (2) years’ duration; or

2. the infertility is associated with one or more of the following medical conditions:

   a. Endometriosis;

   b. Exposure in utero to Diethylstilbestrol, commonly known as DES;

   c. Blockage of or removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or

   d. Abnormal male factors contributing to the infertility.

In vitro fertilization procedures must be performed at a medical facility, licensed or certified by the Arkansas Department of Health, which conform to the American College of Obstetricians and Gynecologists’ guidelines for in vitro fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization and the patient has been unable to obtain successful pregnancy through any less costly applicable infertility treatment for which coverage is available under the policy.
Benefits for in vitro fertilization shall be the same as the benefits provided under maternity benefit provisions and are subject to the same deductibles, co-insurance and out-of-pocket limitations that apply to maternity benefits. Cryopreservation, the procedure whereby embryos are frozen for late implantation, shall be included as an in vitro fertilization procedure.

**Low Protein Modified Food Products**

Covered expenses shall include medically necessary medical foods (food products and formulas) for the therapeutic treatment of a covered person inflicted with an inherited metabolic disorder involving a failure to properly metabolize certain nutrients. The medical foods must be prescribed by a licensed healthcare provider.

**Medical and Surgical Expense Benefits**

Medical covered expenses are limited to charges:

1. For surgery in a physician’s office or at an outpatient surgical facility, including services and supplies;
2. Made by an assistant surgeon;
3. Services of standby physicians are only covered in the event such physician is required to assist with certain high-risk services specified by Arkansas Health & Wellness, and only for such time as such physician is in immediate proximity to the patient;
4. For the professional services of a medical practitioner, including surgery;
5. For electronic consultations between a medical practitioner, with other involved medical practitioners. Benefits include telephone calls or other forms of electronic consultations between a medical practitioner and a covered person, or between a medical practitioner and another medical practitioner;
6. For dressings, crutches, orthopedic splints, braces, casts, or other necessary medical supplies;
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services. This includes advanced diagnostic imaging such as computed tomography scanning (CT SCAN), Magnetic Resonance Angiography or Imaging (MR/MRA), Nuclear Cardiology and positron emission tomography scans (PET SCAN) referred to as—advanced diagnostic imaging. This will require prior authorization from us;
8. For chemotherapy and radiation therapy or treatment on an inpatient or outpatient basis;
9. For hemodialysis, and the charges by a hospital for processing and administration of blood or blood components;
10. For the cost and administration of an anesthetic;
11. For oxygen and its administration;
12. For dental expenses when a covered person suffers an injury, after the covered person’s effective date of coverage, that results in:
   a. Damage to the member’s natural teeth; and
   b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a physician and began within six months of the accident. Injury to the natural teeth will not include any injury as a result of chewing;
13. For reconstructive breast surgery charges as a result of a partial or total mastectomy. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas;
14. Testing of newborn children, including testing for Down’s syndrome, hypothyroidism, sickle-cell anemia, phenylketonuria/galactosemia, PKU and other disorders of metabolism, and spinal muscular dystrophy. Testing for spinal muscular dystrophy will not be subject to a deductible or copayment;
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; and
   e. Implantable prosthetic lenses, in connection with cataracts;

16. Coverage for anesthesia and hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a hospital or ambulatory surgical facility, if the provider certifies that because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures; and the patient is a child under seven (7) years of age who is determined by (2) licensed dentists to require dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; a person with a diagnosed serious mental or physical condition; or a person with a significant behavioral problem;

17. Coverage for gastric pacemakers for covered persons diagnosed with gastroparesis, eligible charges and limits are based on medical necessity and require prior authorization;

18. Infertility counseling and planning services when provided by a network provider, and testing to diagnose infertility;

19. Cochlear implants;

20. Hearing Aids- limited to one pair each three year period;

21. One auditory brain stem implant per lifetime for an individual twelve years of age and older with a diagnosis of Neurofibromatosis Type II (NF2) who has undergone or is undergoing removal of bilateral acoustic tumors;

22. Implantable osseointegrated hearing aid for patients with single-sided deafness and normal hearing in the other ear. Coverage is further limited to members with:
   a. congenital or surgically induced malformations (e.g. atresia) of the external ear canal or middle ear;
   b. chronic external otitis or otitis media, subject to Prior Approval;
   c. tumors of the external canal or tympanic cavity; and
   d. sudden, permanent, unilateral hearing loss due to trauma, idiopathic sudden hearing loss, or auditory nerve tumor; and

23. Testing and evaluation limited to fifteen (15) hours per member per year:
   a. Psychological testing, including but not limited to, assessment of personality, emotionality and intellectual abilities;
   b. For children under the age of six (6), childhood developmental testing, including but not limited to assessment of motor, language, social, adaptive or cognitive function by standardized developmental instruments;
   c. Neurobehavioral status examination, including, but not limited to assessment of thinking, reasoning and judgment;
   d. Neuropsychological testing, including, but not limited to Halstead-Reitan, Luria and WAIS-R.

24. Medically necessary services made by a physician in an urgent care center, including facility costs and supplies;

25. New Intervention (one that is not commonly recognized as a generally accepted standard of medical practice) when it is shown through scientific evidence that the intervention will achieve its intended purpose and will prevent, cure, alleviate or enable diagnosis or detection of a medical condition without exposing the member to risks that outweigh the potential benefits. New interventions in the process of phase I, II or III trials are not covered;

26. Nutritional and Dietary counseling services for members in connection with cleft palate management and for nutritional assessment programs provided in and by a hospital;

27. Allergy testing;

28. For medically necessary genetic blood tests;

29. For medically necessary immunizations to prevent respiratory syncytial virus (RSV);

30. Telemedicine.
31. Oral surgery (non-dental related only) is covered for:
   a. Tumors/cysts (excision when attached to the jaws, cheeks, lips, tongue, roof or floor of mouth when a pathological exam is required);
   b. Exostoses (excision of jaws and hard palate);
   c. Cellulitis (external incision and a drainage); and
   d. Sinuses, salivary glands or ducts (incision of accessory sinuses, salivary glands or ducts).

**Medically Necessary Vision Services**

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

Excluded services for routine and non-routine vision include:

- Visual Therapy for adults is excluded.
- Any vision services, treatment or material not specifically listed as a *covered service*.
- Low vision services and hardware for adults.
- *Non-network* care, only as defined within this document and *Schedule of Benefits*.
- Reading glasses for children may be furnished based on the merits of the individual case. The doctor should indicate why such corrections are necessary. All such requests will be reviewed on a prior approval basis.

**Outpatient Medical Supplies Expense Benefits**

*Covered expenses* for outpatient medical supplies are limited to charges:

1. For artificial eyes and polishing of such, for larynx, breast prosthesis, or basic artificial limbs but not the replacement thereof, unless required by a physical change in the * covered person* and the item cannot be modified. If more than one prosthetic device can meet a *covered person’s* functional needs, only the charge for the most cost effective prosthetic device will be considered a *covered expense*. Coverage provided for eligible charges shall be no less than eighty (80%) of Medicare allowable as defined by the Centers for Medicare & Medicaid Services, Healthcare Common Procedure Coding System;
2. For one pair of foot orthotics per year per *covered person*;
3. For rental of *medically necessary durable medical equipment*;
4. For the rental of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint *surgery*;
5. For a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic *injury* or corneal disease, infectious or non-infectious, and (2) For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract *surgery*. See the *Schedule of Benefits* for benefit levels or additional limits; and
6. For the cost of a monofocal lens, if the multifocal lens is implanted after a cataract extraction.

**Prescription Drug Expense Benefits**

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

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

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

Covered expenses shall include coverage for prescribed drugs or devices approved by the United States Food and Drug Administration for use as a contraceptive.

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

The appropriate drug choice for a covered person is a determination that is best made by the covered person and the covered person’s physician.

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

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

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

Exclusions and Limitations:
No benefits will be paid under this benefit subsection for expenses incurred:

1. For prescription drugs for the treatment of erectile dysfunction or any enhancement of sexual performance, unless listed on the formulary;
2. For immunization agents otherwise not required under the Affordable Care Act;
3. For medication that is to be taken by the covered person, in whole or in part, at the place where it is dispensed;
4. For medication received while the covered person is a patient at an institution that has a facility for dispensing pharmaceuticals;
5. For a refill dispensed more than 12 months from the date of a physician’s order;
6. For more than the predetermined managed drug limitations assigned to certain drugs or classification of drugs;
7. For a prescription order that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary or when the over-the-counter drug is used for preventive care. This exclusion does not apply to prescribed FDA approved contraceptive methods;
8. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs;
9. For more than a 30-day supply when dispensed in any one prescription or refill, or for some maintenance drugs up to a 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply network. Specialty drugs are limited to 30-day supply when dispensed by retail or mail order;
10. For prescription drugs for any covered person who enrolls in Medicare Part D as of the date of the covered person's enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later date;
11. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program;
12. Drugs or dosage amounts determined by Ambetter to be ineffective, unproven or unsafe for the indication for which they have been prescribed, regardless of whether the drugs or dosage amounts have been approved by any governmental regulatory body for that use;
13. Foreign prescription medications, except those associated with an emergency medical condition while you are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this section if obtained in the United States;
14. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations; and
15. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventative treatment is related to member's vacation for out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases; and
16. Medications used for cosmetic purposes.
17. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
18. 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.

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

**Prescription Drug Exception Process**

**Standard exception request**
A member, a member's designee or a member's prescribing physician may request a standard review of a decision that a drug is not covered by the plan. 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.

**Expedit ed 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. We will make our determination on the external exception request and notify the member, the member’s designee or the member’s prescribing physician of our coverage determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception.

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

Pediatric Vision Expense Benefits – Children under the age of 19
Coverage for vision services is provided for children, under the age of 19, from a network provider through the end of the plan year in which they turn 19 years of age.

1. Routine ophthalmological exam
   a. Refraction;
   b. Dilation;
   c. Contact lens fitting.
2. Frames
3. Prescription lenses
   a. Single;
   b. Bifocal;
   c. Trifocal;
   d. Lenticular; or
   e. Contact lenses (in lieu of glasses).
4. Additional lens options (including coating and tints)
   a. Progressive lenses (standard or premium);
   b. Intermediate vision lenses;
   c. Blended segment lenses;
   d. Hi-Index lenses;
   e. Plastic photosensitive lenses;
   f. Photochromic glass lenses;
   g. Glass-grey #3 prescription sunglass lenses;
   h. Fashion and gradient tinting;
   i. Ultraviolet protective coating;
   j. Polarized lenses;
   k. Scratch resistant coating;
   l. Anti-reflective coating (standard, premium or ultra);
   m. Oversized lenses;
   n. Polycarbonate lenses.
5. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.
6. Office-based orthoptic and pleoptic training in the treatment of convergence insufficiency with continuing medical direction and evaluation;
7. Eyeglasses for children diagnosed as having the following diagnoses must have a surgical evaluation in conjunction with supplying eyeglasses:
   a. Ptosis (droopy lid);
   b. Congenital cataracts;
c. Exotropia or vertical tropia;
d. Children between the ages of 12 an 18 exhibiting exotropia;
8. Sensorimotor examination with multiple measurements of ocular deviation; and
9. Eye prosthesis and polishing services.

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.ARHealthWellness.com or call Member Services.

Services not covered:
1. Visual therapy;
2. Two pair of glasses as a substitute for bifocals;

Vision Expense Benefits Routine Vision Adult aged 19 years of age and over
Coverage for vision services is provided for adults, age 19 and older, from a network provider.
1. Routine ophthalmological exam
   a. Refraction;
   b. Dilation;
   c. Contact lens fitting.
2. Frames
3. Prescription lenses
   a. Single;
   b. Bifocal;
   c. Trifocal;
   d. Lenticular; or
   e. Contact lenses (in lieu of glasses).

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.ARHealthWellness.com or call Member Services.

Services not covered:
1. Visual therapy;
2. Low vision services and hardware for adults; and

Dental Benefits – Adults 19 years of age or older
Coverage for dental services is provided for adults, age 19 and older, for Preventative and Diagnostic, Minor Restorative and Major Restorative from a network provider.

1. Preventive and Diagnostic (Basic)-Class 1 benefits include:
   a. Routine Cleanings;
   b. Oral Exams;
   c. X-rays – bite-wing, full-mouth and panoramic film; and
   d. Topical fluoride application.
2. Minor Restorative (Comprehensive) Class 2 benefits include:
   a. Minor Restorative – metal and resin based fillings;
   b. Endodontic therapy;
   c. Periodontics –scaling, root planning and periodontal maintenance;
   d. Simple extractions; and
e. Prosthodontics – relines, rebase, adjustment and repairs.

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

Services not covered include:
1. Out of network services;
2. Dental services that are not necessary or specifically covered;
3. Hospitalization or other facility charges;
4. Prescription drugs dispensed in the dental office;
5. Any dental procedure performed solely as a cosmetic procedure;
6. Charges for dental procedures completed prior to the member's effective date of coverage;
7. Anesthesiologists services;
8. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (wear), realignment of teeth, periodontal splinting, and gnathologic recordings;
9. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles;
10. Any artificial material implanted or grafted into soft tissue, surgical removal of implants, and implant services;
11. Sinus augmentation;
12. Surgical appliance removal;
13. Intraoral placement of a fixation device;
14. Oral hygiene instruction, tobacco counseling, nutritional counseling;
15. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture;
16. Any oral surgery that includes surgical endodontics (apicoectomy and retrograde filling);
17. Analgesia (nitrous oxide);
18. Removable unilateral dentures;
19. Temporary procedures;
20. Splinting;
21. Temporal Mandibular Joint disorder (TMJ) appliances, therapy, films and arthorograms;
22. Tests and examinations;
23. Oral pathology laboratory;
24. Consultations by the treating provider and office visits;
25. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
26. Veneers (bonding of coverings to the teeth);
27. Orthodontic treatment procedures;
28. Orthognathic surgery;
29. Athletic mouth guards; and
30. Space maintainers.
Other Dental Services
Anesthesia and hospital charges for dental care, for a member less than 19 years of age or a member who is physically or mentally disabled, are covered if the member requires dental treatment to be given in a hospital or outpatient ambulatory surgical facility. The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the member’s condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Preventive Care Expense Benefits
Covered expenses are expanded to include the charges incurred by a covered person for the following preventive health services if appropriate for that covered person in accordance with the following recommendations and guidelines:

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual;
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration;
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. Complications resulting from the smallpox vaccine;
6. BRCA genetic cancer testing for women with a family history of certain cancers; and
7. Covers without cost sharing:
   a. Screening for tobacco use; and
   b. For those who use tobacco products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
      i. Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
      ii. All Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a healthcare provider without prior authorization.

Benefits for preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any deductibles or coinsurance provisions, and copayment amounts under the policy when the services are provided by a network provider.

Benefits for covered expenses for preventive care expense benefits may include the use of reasonable medical management techniques authorized by federal law to promote the use of high value preventive services from network providers. Reasonable medical management techniques may result in the application of deductibles or coinsurance provisions, or copayment amounts to services when a covered person chooses not to use a high value service that is otherwise exempt from deductibles or coinsurance provisions, and copayment amounts, when received from a network provider.
As new recommendations and guidelines are issued, those services will be considered *covered expenses* when required by the United States Secretary of Health and Human Services, but not later than one year after the recommendation or guideline is issued.

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

**Colorectal Cancer**
*Covered expenses* shall include colorectal cancer examinations and laboratory tests for *covered persons* who are fifty (50) years of age or older; *covered persons* who are less than fifty (50) years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and *covered persons* experiencing the following symptoms of colorectal cancer as determined by a *physician* licensed under the Arkansas Medical Practices Act: Bleeding from the rectum or blood in the stool; or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days.

Colorectal screening shall involve an examination of the colon, including the following examinations or laboratory tests, or both: (i) An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years; (ii) A double-contrast barium enema every five (5) years; or (iii) A colonoscopy every ten (10) years; and any additional medically recognized screening tests for colorectal cancer required by the Director of the Division of Health of the Department of Health and Human Services, determined in consultation with appropriate health care organizations.

A *covered person* shall determine the choice of screening strategies in consultation with a *healthcare provider*. Screenings shall be limited to the following guidelines: (1) If the initial colonoscopy is normal, follow-up is recommended in ten (10) years; (2) For individuals with one (1) or more neoplastic polyps or adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps, follow-up is recommended in three (3) years; if single tubular adenoma of less than one centimeter (1 cm) is found, follow-up is recommended in five (5) years; and for patients with large sessile adenomas greater than three centimeters (3 cm), especially if removed in piecemeal fashion, follow-up is recommended in six (6) months or until complete polyp removal is verified by colonoscopy.

**Mammography Screening**
*Covered expenses* for a *covered person* shall be paid at the following frequency schedule: Age 35 through 39, one baseline mammogram; Age 40 and older, one mammogram every year. Mammograms without regard to age are covered, upon recommendation from a *physician*, when there is a prior history of breast cancer, family history of breast cancer, positive genetic testing or other risk factors.

**Prostate Cancer Screening**
*Covered expenses* shall include coverage for prostate cancer screenings for a *covered person* 40 years of age or older in accordance with the National Comprehensive Cancer Network guidelines. If recommended by a *physician*, *covered expenses* shall include a prostate specific antigen blood test.

**Maternity Care**
Coverage for maternity care: outpatient and *inpatient* pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other *medically necessary*
reasons less any applicable **deductible**, or **coinsurance**. An *inpatient* stay is covered for at least forty-eight (48) hours following a vaginal delivery, and for at least ninety-six (96) hours following a caesarean delivery. *We do not require a physician or other healthcare provider to obtain prior authorization.* An inpatient stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require **prior authorization**.

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

1. Outpatient and inpatient pre- and post-partum care, including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment and childbirth classes;
2. **Physician** home visits and office services;
3. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests;
4. **Complications of pregnancy**; or
5. Hospital stays for other **medically necessary** reasons associated with maternity care.

**Newborns’ and Mothers’ Health Protection Act Statement of Rights**

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

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery or less than ninety-six (96) hours following a delivery by cesarean section. However, *we may provide benefits for covered expenses incurred for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.* In any case, issuers may not, under federal law, require that a provider obtain **prior authorization** from the issuer for prescribing a length of stay not in excess of 48 hours or 96 hours.

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

**Note:** This provision does not amend the **policy** 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 policy 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.

**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 enrollees. The benefits and services available at any given time are made part of this contract by this reference and are subject to change by us through an update to information available on our website or by contacting us.

Social determinants of health benefits and services may be offered to enrollees through the “My Health Pays” wellness program and through local health plan websites. 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.ARHealthWellness.com or by contacting Member Services at 1-877-617-0390 (TDD/TTY 1-877-617-0392).

**Temporomandibular Joint Disorder and Craniomandibular Disorder Expense Benefits**

Covered service expenses expanded to include the charges incurred for diagnosis and treatment services, both surgical and nonsurgical for temporomandibular joint disorder (TMJ) and craniomandibular disorder. These expenses shall be the same as that for treatment to any other joint in the body. Coverage shall apply if the treatment is administered or prescribed by a physician or dentist.

**Transplant Service Expense Benefits**

Covered expenses for transplant expenses:
If we determine that a covered person is an appropriate candidate for a medically necessary transplant, Medical Benefits covered expenses will be provided for:

1. Pre-transplant evaluation;
2. Pre-transplant harvesting;
3. Pre-transplant stabilization, meaning an inpatient stay to medically stabilize a covered person to prepare for a later transplant, whether or not the transplant occurs;
4. High dose chemotherapy;
5. Peripheral stem cell collection;
6. Post-transplant follow-up; and
7. For donor testing is the donor is found compatible.

Transplant Donor Expenses:

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

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

A covered person may obtain services in connection with a medically necessary transplant from any physician. We will pay a maximum of $10,000 per lifetime for the following services:

a. Transportation for the covered person, any live donor, and the immediate family to accompany the covered person. Reimbursement for miles traveled will be made at the current IRS standard mileage rate for medical purposes.

b. Lodging for any live donor and the immediate family accompanying the covered person while the covered person is confined. We will pay the costs directly for transportation and lodging, however, you must make the arrangements.
Exclusions:
No benefits will be paid under these Transplant Expense Benefits for charges:
1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no medically necessary transplant occurs;
2. For animal to human transplants;
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision;
4. To keep a donor alive for the transplant operation;
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ;
6. Related to transplants deemed not medically necessary;

Trans-telephonic Home Spirometry
Coverage for eligible service expenses for trans-telephonic home or ambulatory spirometry for members who have had a lung transplant.

Wellness and Other Program Benefits
Benefits may be available to enrollees 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.ARHealthWellness.com or by contacting Customer Service by telephone at 1-877-617-0390 (TDD/TTY 1-877-617-0392). 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 enrollees 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 enrollees. 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.

Clinical Trial Coverage
Clinical Trial Coverage includes routine patient care costs incurred as the result of an approved phase I, II, III or phase IV clinical trial and the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition. Coverage will include routine patient care costs incurred for (1) drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient’s particular condition, (2) reasonable and medically necessary services needed to administer the drug or use the device under evaluation in the clinical trial and (3) all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:
- The investigational item or service itself;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

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

- One of the National Institutes of Health (NIH);
- The Centers for Disease Control and Prevention;
- The Agency for Health Care Research and Quality;
- The Centers for Medicare & Medicaid Services;
- A cooperative group or center of any of the entities listed above or the Department of Defense or the Department of Veteran Affairs;
- An NIH Cooperative Group or Center;
- The FDA in the form of an investigational new drug application;
- The federal Departments of Veterans’ Affairs, Defense, or Energy;
- An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects;
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application; or
- A qualified non-governmental research entity that meets the criteria for NIH Center support grant eligibility.

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

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

Second Medical Opinion

Members are entitled to a second medical opinion under the following conditions:

1. Whenever a minor surgical procedure is recommended to confirm the need for the procedure;
2. Whenever a serious injury or illness exists; or
3. Whenever you find that you are not responding to the current treatment plan in a satisfactory manner.

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

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

For services or supplies that require prior authorization, as shown on the Schedule of Benefits, you must obtain authorization from us before you or your dependent member:
1. Receives a service or supply; or
2. Are admitted into a facility.

Prior Authorization requests must be received by phone/eFax/provider portal as follows:
1. At least 5 days prior to an elective admission as an inpatient in a hospital, extended care or rehabilitation facility, or hospice facility.
2. At least 30 days prior to the initial evaluation for organ transplant services.
3. At least 30 days prior to receiving clinical trial services.
4. Within 24 hours of an inpatient admission, including emergent inpatient admission.
5. At least 5 days prior to the start of home healthcare except members needing home health care after hospital discharge.

After prior authorization has been requested and all required or applicable documentation has been submitted, we will notify you and your provider if the request has been approved as follows:
1. For immediate request situations, within one business day, when the lack of treatment may result in an emergency room visit or emergency admission.
2. For urgent concurrent review within 24 hours of receipt of the request.
3. For urgent pre-service, within one business day of receipt of all information, but no later than 72 hours from date of receipt of request.
4. For non-urgent pre-service requests within two business days of receipt of all information, but no later than 15 days of receipt of the request.
5. For post-service requests, within 30 calendar days of receipt of the request.

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

Failure to Obtain Prior Authorization
Failure to comply with the prior authorization requirements will result in benefits being reduced.

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

In cases of emergency, benefits will not be reduced for failure to comply with prior authorization requirements. However, you must contact us as soon as reasonably possible after the emergency occurs.

Prior Authorization Does Not Guarantee Benefits
Our authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the policy.
Requests for Predeterminations
You may request a predetermination of coverage. We will provide one if circumstances allow us to do so. However, we are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination we may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause us to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by us.
2. Another party has already paid or is responsible for payment of the medical expense.

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

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

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

No benefits will be paid for:

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

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

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

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

1. For services or supplies that are provided prior to the effective date or after the termination date of this policy;
2. For any portion of the charges that are in excess of the eligible expense;
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery, bariatric surgery and weight loss programs;
4. For cosmetic breast reduction or augmentation (does not include reduction mammoplasty or gender dysphoria when deemed medically necessary by us);
5. For the reversal of sterilization and the reversal of vasectomies;
6. For an elective abortion for any reason other than:
   a. To prevent the death of the mother upon whom the abortion is performed. However, an abortion shall not be deemed an elective abortion to prevent the death of the mother based on a claim or diagnosis that without the abortion the mother will engage in conduct that will result in the mother’s death; or
   b. In a pregnancy resulting from rape or incest.
7. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in covered expenses of the Medical Benefits provision;
8. For expenses for television, telephone, or expenses for other persons;
9. For telephone consultations, except those meeting the definition of telehealth services, or for failure to keep a scheduled appointment;
10. For stand-by availability of a medical practitioner when no treatment is rendered;
11. For dental expenses, including braces for any medical or dental condition, surgery and treatment for oral surgery, except as expressly provided for under Medical Benefits;
12. For cosmetic treatment, except for reconstructive surgery that is incidental to or follows surgery or an injury that was covered under the policy or is performed to correct a birth defect in a child who has been a covered person from its birth until the date surgery is performed;
13. For mental health exams and services involving:
   a. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
   b. Pre-marital counseling;
   c. Court-ordered care or testing, or required as a condition of parole or probation. Benefits will be allowed for services that would otherwise be covered under this policy;
   d. Testing of aptitude, ability, intelligence or interest; and
e. Evaluation for the purpose of maintaining employment.

14. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Expense Benefits;

15. For eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism;

16. While confined primarily to receive rehabilitation, custodial care, educational care, or nursing services, unless expressly provided for by the policy;

17. For vocational or recreational therapy, vocational rehabilitation, outpatient speech therapy, or occupational therapy, except as expressly provided for in this policy;

18. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs;

19. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the policy;

20. For experimental or investigational treatment(s) or unproven services. The fact that an experimental or investigational treatment or unproven service is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an experimental or investigational treatment or unproven service for the treatment of that particular condition;

21. For treatment received outside the United States, except for a medical emergency while traveling for up to a maximum of ninety (90) consecutive days;

22. As a result of an injury or illness arising out of, or in the course of, employment for wage or profit, if the covered person is insured, or is required to be insured, by workers’ compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a covered person’s right to recover future medical benefits under a workers’ compensation law or insurance plan, this exclusion will still apply. In the event that the workers’ compensation insurance carrier denies coverage for a covered person’s workers’ compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency;

23. As a result of:
   a. An injury or illness caused by any act of declared or undeclared war;
   b. The covered person taking part in a riot; or
   c. The covered person’s commission of a felony, whether or not charged;

24. Surrogacy Arrangement. Health care services, including supplies and medication, to a surrogate, including a member acting as a surrogate or utilizing the services of a surrogate who may or may not be a member, and any child born as a result of a surrogacy arrangement. This exclusion applies to all health care services, supplies and medication to a surrogate including, but not limited to:
   a. Prenatal care;
   b. Intrapartum care (or care provided during delivery and childbirth);
   c. Postpartum care (or care for the surrogate following childbirth);
   d. Mental health services related to the surrogacy arrangement.
   e. Expenses relating to donor semen, including collection and preparation for implantation;
   f. Donor gamete or embryos or storage of same relating to a surrogacy arrangement;
   g. Use of frozen gamete or embryos to achieve future conception in a surrogacy arrangement;
   h. Preimplantation genetic diagnosis relating to a surrogacy arrangement;
   i. Any complications of the child or surrogate resulting from the pregnancy; or
   j. Any other health care services, supplies and medication relating to a surrogacy arrangement.
   k. Any and all health care services, supplies or medication provided to any child birthed by a surrogate as a result of a surrogacy arrangement are also excluded, except where the child is the adoptive child of insureds possessing an active policy with us and/or the child possesses an active policy with us at the time of birth.
25. For or related to treatment of hyperhidrosis (excessive sweating);
26. For fetal reduction surgery;
27. Except as specifically identified as a covered expense under the policy, expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health;
28. As a result of any injury sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or semi-professional sports; intercollegiate sports not including intramural sports; racing or speed testing any motorized vehicle or conveyance, if the covered person is paid to participate or to instruct; racing or speed testing any non-motorized vehicle or conveyance, if the covered person is paid to participate or to instruct; rodeo sports; horseback riding, if the covered person is paid to participate or to instruct; rock or mountain climbing, if the covered person is paid to participate or to instruct; or skiing, if the covered person is paid to participate or to instruct;
29. As a result of any injury sustained while operating, riding in, or descending from any type of aircraft if the covered person is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft;
30. For prescription drugs for any covered person who enrolls in Medicare Part D as of the date of the covered person’s enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later date;
31. For the following miscellaneous items: artificial insemination except where required by federal or state law; biofeedback; care or complications resulting from non-covered expenses; chelating agents; domiciliary care; food and food supplements; routine foot care, foot orthotics, corrective shoes, or orthopedic shoes that are not attached to an appliance; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-member biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; private duty nursing; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service area; sclerotherapy for varicose veins; treatment of spider veins; transportation expenses; unless specifically described in this policy;
32. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment;
33. 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; and
34. Services or supplies eligible for payment under either federal or state programs (except Medicaid). This exclusion applies whether or not you assert your rights to obtain this coverage or payment of these services.
35. 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.

Limitation On Benefits For Services Provided By Medicare Opt-Out Practitioners
Benefits for covered expenses incurred by a Medicare-eligible individual for services and supplies provided by a Medicare opt-out practitioner will be determined as if the services and supplies had been provided by a Medicare participating practitioner. Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a Medicare participating practitioner.
TERMINATION

Termination of Policy
All insurance will cease on termination of this policy. This policy will terminate on the earliest of:
1. The date that a member has failed to pay premiums or contributions in accordance with the terms of this policy (including, but not limited to, the Grace Period provision) or the date that we have not received timely premium payments in accordance with the terms of this policy;
2. The date we receive a request from you to terminate this policy, or any later date stated in your request, or if you are enrolled through Marketplace, the date of termination that the Marketplace provides us upon your request of cancellation to the Marketplace;
3. The date we decline to renew this policy, as stated in the Discontinuance provision;
4. The date of your death, if this policy is an Individual Plan;
5. The date the member has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact;
6. The date a covered person's eligibility for insurance under this policy ceases due to any of the reasons stated in the Ongoing Eligibility section in this policy; or
7. For an eligible child reaching the limiting age of 26, coverage under this policy for an eligible child will terminate at 11:59 p.m. on the last day of the year in which the eligible child reaches the limiting age of 26.

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

Discontinuance
90-Day Notice:
If we discontinue offering and decide not to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least ninety (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 policy. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180-Day Notice:
If we discontinue offering and refuse to renew all individual policies/certificates 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 one hundred eighty (180) days prior to the date that we stop offering and terminate all existing individual policies in the individual market in the state where you reside.

Continuity of Care
We shall develop procedures to provide for the continuity of care of members. We shall ensure that:
(1) When a member is enrolled in an Ambetter plan and is being treated by a non-network provider for a current episode of an acute condition, the member may continue to receive treatment as an in-network benefit from that provider until the current episode of treatment ends or until the end of ninety (90) days, whichever occurs first; and
(2) When a provider's participation is terminated, the provider's patients under the plan may continue to receive care from that provider as an in-network benefit until a current episode of treatment for an acute condition is completed or until the end of ninety (90) days, whichever occurs first.

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

As used herein, the term “third party” means any party that is, or may be, or is claimed to be responsible for illness or injuries to a covered person. 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 a covered person’s illness or injury is caused by the acts or omissions of a third party, we will not cover a loss to the extent that it is paid as part of a settlement or judgment by any third party.

If this plan provides benefits under this contract to a covered person 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 covered person that are associated with the third party injuries. The plan’s rights of recovery apply to any recoveries made by or on behalf of the covered person from any sources, including, but not limited to:
- Payments made by a third party or any insurance company on behalf of the third party;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers’ Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and
- Any other payments from a source intended to compensate a covered person for third party injuries.

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

By accepting benefits under this plan, the covered person also specifically acknowledges Arkansas Health & Wellness’s right of reimbursement. This right of reimbursement attaches when this plan has provided health care benefits for expenses incurred due to third party injuries and the covered person or the covered person’s representative has recovered any amounts from any source. By providing any benefit under this plan, Arkansas Health & Wellness 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. Arkansas Health & Wellness’s right of reimbursement is cumulative with and not exclusive of Arkansas Health & Wellness’s subrogation right and Arkansas Health & Wellness may choose to exercise either or both rights of recovery.

As a condition for our payment, the covered person or anyone acting on the covered person’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 immediately inform us in writing of any claim made or lawsuit filed on behalf of a covered person in connection with the loss;
3. To include the amount of benefits paid by us on behalf of a covered person in any claim made against any third party;
4. To give Arkansas Health & Wellness a first-priority lien on any recovery, settlement or judgment or other sources of compensation which may be had from any party to the extent of the full cost of all benefits associated with third party injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
5. To pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due Arkansas Health & Wellness as reimbursement for the full
cost of all benefits associated with third party injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement);

6. That we:
   a. Will have a lien on all money received by a covered person in connection with the loss equal to the amount we have paid;
   b. May give notice of that lien to any third party or third party's agent or representative;
   c. Will have the right to intervene in any suit or legal action to protect our rights;
   d. Are subrogated to all of the rights of the covered person against any third party to the extent of the benefits paid on the covered person's behalf; and
   e. May assert that subrogation right independently of the covered person;

7. To take no action that prejudices our reimbursement and subrogation rights, including, but not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan;

8. To sign, date, and deliver to us any documents we request that protect our reimbursement and subrogation rights;

9. To not settle any claim or lawsuit against a third party without providing us with written notice of the intent to do so;

10. To reimburse us from any money received from any third party, to the extent of benefits we paid for the illness or injury, whether obtained by settlement, judgment, or otherwise, and whether or not the third party's payment is expressly designated as a payment for medical expenses; and

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

Our right of subrogation and reimbursement only exists to the extent the covered person has been made whole. Any costs associated with subrogation shall be shared in the same proportion as each participant shared in the recovery amount.
COORDINATION OF BENEFITS

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

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

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

“Allowable expense” is the necessary, reasonable, and customary item of expense for healthcare, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid. When Medicare is the primary plan, Medicare’s allowable expense is the allowable expense when we are paying claims as the secondary plan.

1. If a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan’s deductible is not an allowable expense, except for any health care 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 or a portion of an expense that is not covered by any of the plans is not an allowable expense.
3. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

a) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense, unless one of the plans provides coverage for hospital room expenses.

b) If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.

c) If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

d) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan’s payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefits or services for a specific negotiated fee or payment amount that is different than the primary plan’s payment arrangement and if the provider’s contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.
The term “Plan” includes:
1. Group and non-group insurance contracts and subscriber contracts;
2. Uninsured arrangements of group or group-type coverage;
3. Group and non-group coverage through closed panel plans;
4. Group-type contracts;
5. The medical Care components of long-term care contracts, such as skilled nursing care;
6. The medical benefits coverage in automobile “no fault” and traditional automobile “fault” type contract; and
7. Medicare or other governmental benefits, as permitted by law, except as provided in Paragraph (4)(h). The part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

The term “Plan” does not include:
1. Hospital indemnity coverage benefits or other fixed indemnity coverage;
2. Accident only coverage;
3. Specified disease or specified accident coverage;
4. Limited benefit health coverage;
5. School accident-type coverages that cover students for accident only, including athletic injuries, whether on a twenty-four hour basis or on a “to and from school” basis.
6. Benefits provided in long-term care insurance policies of non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefits without regard to expense incurred or the receipt of services;
7. Medicare supplement polices;
8. A state plan under Medicaid; or
9. A governmental plan, which by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

“Primary plan” is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either:
1. the plan has no order of benefits rules or its rules differ from those required by regulation; or
2. all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

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

**Order of Benefit Determination Rules**
The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:
1. The Primary plan pays or provides its benefits as if the Secondary plan or plans did not exist. A Plan may consider benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other plan.
2. If the other plan does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:
   a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, and
b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

3. Each plan determines its order of benefits using the first of the following rules that apply:
   a. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.
   b. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:
      (i) If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the calendar year (excluding year of birth) shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary.
      (ii) If a child is covered by both parents’ plans, the parents are separated or divorced, whether or not they have ever been married:
         A. If a court order or decree states that one of the parents is responsible for the dependent child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child’s health care expenses, but that parent’s spouse does, that parent’s spouse’s plan is the primary plan. This rule applies to the plan years commencing after the plan is given notice of the court decree;
         B. If a court order or decree states that both parents are responsible for or orders joint custody without considering for the dependent child’s health care expenses or health care coverage, the provisions of subparagraph (i) above shall determine the order of benefits.
         C. If the parent with custody has remarried, and the child is also covered as a child under the step-parent’s plan will pay second, and the plan of the parent without custody will pay third;
         D. If there is no court order or decree allocating responsibility for the dependent child’s health care expenses or health care coverage, the order of benefits for the child are as follows:
            1) The plan covering the custodial parent;
            2) The plan covering the spouse of the custodial parent;
            3) The plan covering the non-custodial parent; and then
            4) The plan covering the spouse of the non-custodial parent.
      (iii) For a dependent child covered under more than one plan of individuals who are the parents of the child, the provisions of subparagraph I or ii above shall determine the order of benefits as if those individuals were the parents of the child.

4. Active Employee or Retired or Laid-off Employee. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which...
5. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 3(a) can determine the order of benefits.

6. **Longer or Shorter Length of Coverage.** The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

7. **If the preceding rules do not determine the order of benefits,** the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

**Effects of Coordination**

When this plan is secondary, we may reduce benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, we will calculate the benefits we would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under this plan that is unpaid by the primary plan. We may then reduce our payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, we shall credit to our plan deductible any amounts we would have credited to the deductible in the absence of other health care coverage. Also, the amount we pay will not be more than the amount we would pay if we were primary. When this plan is secondary as a result of one of our members being a Medicare beneficiary, see above definition for allowable expense, as we will reduce our benefits up to Medicare’s allowable.

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

**Right to Receive and Release Needed Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. We need not tell or get the consent of, any person to do this.

**Right of Recovery**

If the amount of the payments made by this plan is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.
CLAIMS

Notice of Claim
We must receive notice of claim within 30 days of the date the loss began or as soon as reasonably possible. Notice given by or on behalf of the insured to Ambetter from Arkansas Health & Wellness, Attn.: Claims Department, P.O. Box 5010, Farmington, MO 63640-3800, with information sufficient to identify the insured, shall be deemed notice to us.

Claim Forms
Upon receipt of a notice of claim, we will furnish you with forms for filing proofs of loss. If we do not provide you with such forms within fifteen (15) days after you have given us notice, you shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time required for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Loss
We must receive written proof of loss within one hundred eighty (180) days of the loss or as soon as is reasonably possible.

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

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

If any covered person, or other person acting on the covered person’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 policy.

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

Time for Payment of Claims
Benefits will be paid within 30 days after receipt of proof of loss. Should we determine that additional supporting documentation is required to establish responsibility of payment, we shall pay benefits within 30 days after receipt of additional supporting documentation.

We will pay or deny a clean claim within 30 days of receipt if the claim was submitted electronically or within 45 days after receipt if the claim was submitted by other means. We will pay 12% interest after the 61st day of nonpayment.
Payment of Claims
Except as set forth in this provision, all benefits are payable to you. Any accrued benefits unpaid at your death, or your dependent’s death may, at our option, be paid either to the beneficiary or to the estate. If any benefit is payable to your or your dependent’s estate, or to a beneficiary who is a minor or is otherwise not competent to give valid release, we may pay up to $1,000 to any relative who, in our opinion, is entitled to it.

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

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

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

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

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

No Third Party Beneficiaries
This policy is not intended to, nor does it, create or grant any rights in favor of any third party, including but not limited to any hospital, provider or medical practitioner providing services to you, and this policy shall not be construed to create any third party beneficiary rights.

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

We will pay the benefits of this policy to the state if:
1. A covered person is eligible for coverage under the state’s Medicaid program; and
2. We receive proper proof of loss and notice that payment has been made for covered expenses under that program.

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

Insurance With Medicare
If a person is also a Medicare beneficiary, benefits will be coordinated in compliance with federal law.

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

Upon request by the custodial parent, we will:

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

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

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

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

No action at law or in equity may be brought against us under the policy for any reason unless the covered person first completes all the steps in the complaint/grievance procedures made available to resolve disputes in your state under the policy. After completing that complaint/grievance procedures process, if you want to bring legal action against us on that dispute, you must do so within three years of the date we notified you of the final decision on your complaint/grievance.
INTERNAL CLAIMS AND APPEALS PROCEDURES AND EXTERNAL REVIEW

Overview

If you need help: If you do not understand your rights or if you need assistance understanding your rights or you do not understand some or all of the information in the following provisions, you may contact Ambetter from Arkansas Health & Wellness, at the Member Services Department, Post Office Box 25538, Little Rock, Arkansas 72221, by telephone at 1-877-617-0390, by fax at 1-866-811-3255 or Ambetter.ARHealthWellness.com.

Internal Claims and Appeals Procedures: When a health insurance plan denies a claim for a treatment or service (a claim for plan benefits, you have already received (post-service claim denial) or denies your request to authorize treatment or service (pre-service claim denial), you, or someone you have authorized to speak on your behalf (an authorized representative), can request an appeal of the plan’s decision. If the plan rescinds your coverage or denies your application for coverage, you may also appeal the plan’s decision. When the plan receives your appeal, it is required to review its own decision. When the plan makes a claim decision, it is required to notify you (provide notice of an adverse benefit determination):

1. The reasons for the plan’s decision;
2. Your right to file appeal the claim decision;
3. Your right to request an external review; and
4. The availability of a Consumer Services Division at The Arkansas Department of Insurance.
5. NOTE: If you do not speak English, you may be entitled to receive appeals’ information in your native language upon request.

When you request an internal appeal, the plan must give you its decision as soon as possible, but no later than:

1. 72 hours after receiving your request when you are appealing the denial of a claim for urgent care. (If your appeal concerns urgent care, you may be able to have the internal appeal and external reviews take place at the same time.)
2. 30 days for appeals of denials of non-urgent care you have not yet received.
3. 60 days for appeals of denials of services you have already received (post-service denials).
4. No extensions of the maximum time limits are permitted unless you consent.

Continuing Coverage: The plan cannot terminate your benefits until all of the appeals have been exhausted. However, if the plan’s decision is ultimately upheld, you may be responsible for paying any outstanding claims or reimbursing the plan for claims’ payments it made during the time of the appeals.

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

Defined terms: Any terms appearing in italics are defined.

Emergency medical services: If the plan denies a claim for an emergency medical service, your appeal will be handled as an urgent appeal. The plan will advise you at the time it denies the claim that you can file an expedited internal appeal. If you have filed for an expedited internal appeal, you may also file for an expedited external review (see “Simultaneous urgent claim, expedited internal review and external review”).
Your rights to file an appeal of denial of health benefits: You or your authorized representative, such as your healthcare provider, may file the appeal for you, in writing, either by mail or by facsimile (fax). For an urgent request, you may also file an appeal by telephone:

Ambetter from Arkansas Health & Wellness, at the Appeals Unit, P.O. Box 25538, Little Rock, AR 72221, by telephone at 1-877-617-0390, by fax at 1-866-811-3255 or Ambetter.ARHealthWellness.com.

Please include in your written appeal or be prepared to tell us the following:
1. Name, address and telephone number of the insured person;
2. The insured's health plan identification number;
3. Name of healthcare provider, address and telephone number;
4. Date the healthcare benefit was provided (if a post-claim denial appeal);
5. Name, address and telephone number of an authorized representative (if appeal is filed by a person other than the insured); and
6. A copy of the notice of adverse benefit determination.

Recession of coverage: If the plan rescinds your coverage, you may file an appeal according to the following procedures. The plan cannot terminate your benefits until all of the appeals have been exhausted. Since a recession means that no coverage ever existed, if the plan’s decision to rescind is upheld, your premium will be returned minus any benefits paid. You will be responsible for payment of all claims for your healthcare services.

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

In general, the health plan may unilaterally extend the time for providing a decision on both pre-service and post-service claims for 15 days after the expiration of the initial period, if the plan determines that such an extension is necessary for reasons beyond the control of the plan. There is no provision for extensions in the case of claims involving urgent care.

Time Limits for an External Appeal: You have 120 days to file for an external review after receipt of the plan’s final adverse benefit determination.

Your Rights to a Full and fair review. The plan must allow you to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.
1. The plan must provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to give you a reasonable opportunity to respond prior to that date; and

2. Before the plan can issue a final internal adverse benefit determination based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

3. The adverse determination must be written in a manner understood by you, or if applicable, your authorized representative and must include all of the following:
   a. The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);
b. Information sufficient to identify the claim involved, including the date of service, the healthcare provider; and

c. A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

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

Other Resources to help you

{Department of Insurance: For questions about your rights or for assistance you may also contact the Consumer Services Division at The Arkansas Department of Insurance (800) 852-5494.

Language services are available from the health benefit plan.

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

INTERNAL CLAIMS AND APPEALS

Non-urgent, pre-service claim denial

For a non-urgent pre-service claim, the plan will notify you of its decision as soon as possible but no later than 30 days after receipt of the claim.

If the plan needs more time, it will contact you, in writing, telling you the reasons why it needs more time and the date when it expects to have a decision for you, which should be no later than 30 days.

If the plan needs additional information from you before it can make its decision, it will provide a notice to you, describing the information needed. You will have 45 days from the date of the plan’s notice to provide the information. If you do not provide the additional information, the plan can deny your claim. In which case, you may file an appeal.

Urgent Pre-service Care claim denial

If your claim for benefits is urgent, you or your authorized representative, or your healthcare provider (physician) may contact us with the claim, orally or in writing.

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

If you have not given us sufficient information, we will contact you as soon as possible but no more than 24 hours after we receive your claim to let you know the specific information we will need to make a decision. You must give us the specific information requested as soon as you can but no later than 48 hours after we have asked you for the information.

We will notify you of our decision as soon as possible but no later than 48 hours after we have received the needed information or the end of the 48 hours you had to provide the additional information.

To assure you receive notice of our decision, we will contact you by telephone or facsimile (fax) or by another method meant to provide the decision to you quickly.
In determining whether a claim involves urgent care, the plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. **However, if a physician with knowledge of your medical condition determines that a claim involves urgent care, or an emergency, the claim must be treated as an urgent care claim.**

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

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

**Simultaneous urgent claim, expedited internal review and external review:**
You, or your authorized representative, may request an expedited external review if both the following apply

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

**Concurrent care decisions**

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

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

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

**Concurrent urgent care and extension of treatment:** Under the concurrent care provisions, any request that involves both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved by the plan must be decided as soon as possible, taking into account the medical urgencies, and notification must be provided to the claimant within 24 hours after receipt of the claim, provided the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.
Non-urgent request to extend course of treatment or number of treatments: If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the plan does not involve urgent care, the request may be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, e.g., as a pre-service claim or a post-service claim. If the request is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request must be treated as a claim involving urgent care and decided in accordance with the urgent care claim timeframes, e.g., as soon as possible, taking into account the medical emergencies, but not later than 72 hours after receipt.

Post-service appeal of a claim denial (retrospective)
If your appeal is for a post-service claim denial, we will notify you of our decision as soon as possible but no later than 60 days after we have received your appeal. If we need more time, we will contact you, telling you about the reasons why we need more time and the date when we expect to have a decision for you, which should be no later than 15 days, provided that the we determine that such an extension is necessary due to matters beyond our control, and we notify you prior to the expiration of the initial 30 days period. If the reason we need more time to make a decision is because you have not given us necessary information, you will have 45 days from the date we notify you to give us the information. We will describe the information needed to make our decision in the notice we send you. This is also known as a “retrospective review.” The plan will notify you of its determination as soon as possible but no later than 5 days after the benefit determination is made.

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

EXTERNAL REVIEW

Right to External Review
Under certain circumstances, you have a right to request an external review of our adverse benefit decision by an independent review organization or by the Insurance Commissioner, or both.

If you have filed internal claims and appeals according with the procedures of this plan, and the plan has denied or refused to change its decision, or if the plan has failed, because of its actions or its failure to act, to provide you with a final determination of your appeal within the time permitted, or if the plan waives, in writing, the requirement to exhaust the internal claims and appeals procedures, you may make a request for an external review of an adverse benefit determination.

All requests for an external review must be made within 120 days of the date of the notice of the plan's final adverse benefit determination. Standard requests for an external review must be provided in writing; requests for expedited external reviews, including experimental/investigational, may be submitted orally or electronically. When an oral or electronic request for review is made, written confirmation of the request must be submitted to the plan no later than 5 days after the initial request was made.

You may file the request for an external review by contacting the Arkansas Insurance Department External Review Division, Arkansas Insurance Department at 1200 West 3rd Street, Little Rock, AR 72201 or via email to: insurance.Consumers@arkansas.gov. Information about external reviews is also available on the Department’s website: http://insurance.arkansas.gov/csd.htm.
Non-urgent request for an external review
Unless the request is for an expedited external review, the plan will initiate an external review within 5 days after it receives your written request if your request is complete. The plan will provide you with notice that it has initiated the external review that includes:
(a) The name and contact information for the assigned independent review organization or the Insurance Commissioner, as applicable, for the purpose of submitting additional information; and
(b) Except for when an expedited request is made, a statement that you may, with 10 business days after the date of receipt of the notice, submit, in writing, additional information for either the independent review organization or the Insurance Commissioner to consider when conducting the external review.

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

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

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

Expedited external review: You may have an expedited external review if your treating provider certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of you (claimant), or would jeopardize your ability to regain maximum function if treated after the time frame for a standard external review; or the final adverse benefit determination concerns an admission, availability of care, continued stay, or healthcare service for which you received emergency services, but have not yet been discharged from a facility.

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

To be eligible for an external review under this provision, your treating provider shall certify that one of the following situations is applicable:
1. Standard healthcare services have not been effective in improving your condition;
2. Standard healthcare services are not medically appropriate for you; or
3. There is no available standard healthcare service covered by the health plan issuer that is more beneficial than requested healthcare service.
If the request for an expedited external review is complete and eligible, the plan will immediately provide or transmit all necessary documents and information considered in making the adverse benefit determination in question to the assigned independent review organization (IRO) by telephone, facsimile or other available expeditious method.

If the request is not complete, we will notify you immediately, including what is needed to make the request complete.

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

If an expedited external review (urgent) was requested, the IRO will provide a determination as soon as possible or within 72 hours of receipt of the expedited request. The IRO’s decision is binding on the company. If the IRO reverses the health benefit plan’s decision, the plan will immediately provide coverage for the healthcare service or services in question.

If the Insurance Commissioner or IRO requires additional information from you or your healthcare provider, the plan will tell you what is needed to make the request complete.

If the plan reverses its decision: If the plan decides to reverse its adverse determination before or during the external review, the plan will notify you, the IRO, and the Insurance Commissioner within one business day of the decision.

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

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

If the IRO and Insurance Commissioner uphold the plan’s decision, you may have a right to file a lawsuit in any court having jurisdiction.
GENERAL PROVISIONS

Entire Contract
This policy, with the application, is the entire contract between you and us. No agent may:
1. Change this policy;
2. Waive any of the provisions of this policy;
3. Extend the time for payment of premiums; or
4. Waive any of our rights or requirements.

All riders or endorsements added to the policy after the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the insured. After date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law.

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 policy that will not be considered a waiver of any rights under the policy. A past failure to strictly enforce the policy will not be a waiver of any rights in the future, even in the same situation or set of facts.

Rescissions
No misrepresentation of fact made regarding a covered person during the application process that relates to insurability will be used to void/rescind the insurance coverage or deny a claim unless:
1. The misrepresented fact is contained in a written application, including amendments, signed by a covered person;
2. A copy of the application, and any amendments, has been furnished to the covered person(s), or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to our determination to issue coverage to any covered person. A covered person's coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. “Rescind” has a retroactive effect and means the coverage was never in effect.

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

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

Conditions Prior To Legal Action
On occasion, we may have a disagreement related to coverage, benefits, premiums, or other provisions under this policy. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process. Therefore, with a view to avoiding litigation, you must give written notice to us of your intent to sue us as a condition prior to bringing any legal action. Your notice must:
1. Identify the coverage, benefit, premium, or other disagreement;
2. Refer to the specific policy provision(s) at issue; and
3. Include all relevant facts and information that support your position.

Unless prohibited by law, you agree that you waive any action for statutory or common law extra-contractual or punitive damages that you may have if the specified contractual claims are paid, or the issues giving rise to the disagreement are resolved or corrected, within thirty (30) days after we receive your notice of intention to sue us.
Statement of Non-Discrimination

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

Ambetter from Arkansas Health & Wellness:

- 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 Arkansas Health & Wellness at 1-877-617-0390 (TTY/TDD 1-877-617-0392).

If you believe that Ambetter from Arkansas Health & Wellness has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ambetter from Arkansas Health & Wellness Appeals Unit, P.O. Box 25538, Little Rock, AR 72221, 1-877-617-0390 (TTY/TDD 1-877-617-0392), Fax 1-866-811-3255. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from Arkansas Health & Wellness 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).