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2020 Evidence of Coverage

Ambetter.SunflowerHealthPlan.com

THIS CONTRACT REFLECTS THE KNOWN REQUIREMENTS FOR COMPLIANCE UNDER THE AFFORDABLE CARE ACT AS PASSED ON MARCH 23, 2010. AS ADDITIONAL GUIDANCE IS FORTHCOMING FROM THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND THE KANSAS INSURANCE DEPARTMENT, THOSE CHANGES WILL BE INCORPORATED INTO YOUR HEALTH INSURANCE POLICY.

AMBETTER FROM SUNFLOWER HEALTH PLAN
Underwritten by Sunflower State Health Plan, Inc.

Home Office:
8325 Lenexa Dr.
Suite 200,
Lenexa, KS 66214
Phone No. 1-844-518-9505
Ambetter.sunflowerhealthplan.com
Claims Office: P.O. Box 5010, Farmington, MO 63640-5010

Individual Major Medical Expense Insurance Policy

In this *contract,* the terms *you* or *your* or *yours* will refer to the *member* or *dependent*s enrolled in this contract, and *we, our,* or *us* will refer to Sunflower Health Plan or Ambetter from Sunflower Health Plan.

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

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

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

Annually, *we* may change the rate table used for this *contract* form. Each premium will be based on the rate table in effect on that premium's due date. The *contract* plan, and age of *members,* type and level of benefits, and place of *residence* on the premium due date are some of the factors used in determining *your* premium rates. We have the right to change premiums, however, all premium rates charged will be guaranteed for a rating period of at least 12 months.

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

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

TEN DAY RIGHT TO RETURN POLICY

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

IMPORTANT NOTICE:

Please read the copy of the application attached to this policy. Carefully check the application and write to P.O. Box 5010, Farmington, MO 63640-5010 within 10 days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. This application is a part of the policy and the policy was issued on the basis that answers to all questions and the information shown on the application are correct and complete.

IMPORTANT INFORMATION

This *contract* reflects the known requirements for compliance under The Affordable Care Act as passed on March 23, 2010. As additional guidance is forthcoming from the US Department of Health and Human Services, and the Kansas Insurance Department, those changes will be incorporated into your health insurance *contract*.

The coverage represented by this *contract* is under the jurisdiction of the Kansas Insurance Commissioner.

This contract does not include pediatric dental services. Pediatric dental coverage is included in some health plans, but can also be purchased as a standalone product. Please contact your insurance carrier or producer, or seek assistance through Healthcare.gov, if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

Should this *contract* be purchased Off the Marketplace, then any and all references to the Marketplace are not applicable.

Michael Stephens
Plan President & CEO

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INTRODUCTION

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

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

This *contract*, the *schedule of benefits*, the application as submitted to the Marketplace, and any amendments or riders attached shall constitute the entire *contract* under which *covered services* and supplies are provided or paid for by *us*.

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

How to Contact Us
Ambetter from Sunflower Health Plan
8325 Lenexa Dr.
Suite 200
Lenexa, KS 66214

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

Member Services	**1-844-518-9505**
TDD/TTY line	**1-844-546-9713**
Emergency	**911**
24/7 Nurse Advice Line	**1-844-518-9505**

Interpreter Services
Ambetter from Sunflower Health Plan has a free service to help members who speak languages other than English. These services ensure that you and your physician can talk about your medical or behavioral health concerns in a way that is most comfortable for you.
Our interpreter services are provided at no cost to *you*. We have representatives that speak Spanish and have medical interpreters to assist with languages other than English via phone. 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.

To arrange for interpretation services, please call Member Services at 1-844-518-9505 or for the hearing impaired (TTY/TDD 1-844-546-9713).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting *you* as a *member*.
2. Encouraging open discussions between *you*, and *your provider(s)*.
3. Providing information to help *you* become an informed healthcare consumer.
4. Providing access to *covered services* and *our network providers*.
5. Sharing *our* expectations of *you* as a *member*.
6. Providing coverage regardless of age, ethnicity, race, religion, gender, sexual orientation, national origin, physical or mental disability, and/or expected health or genetic status.

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 providers* 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 *providers*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from *your primary care provider* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care provider* can tell *you* about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for *your* approval for treatment unless there is an *emergency* and *your* life and health are in serious danger.
8. Make recommendations regarding *member*'s rights, responsibilities and policies.
9. Voice *complaints* or *grievances* about: *our* organization, any benefit or coverage decisions *we*

(or *our* designated administrators) make, *your* coverage, or care provided.

10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
11. See *your* medical records.
12. Be kept informed of *covered* and non-*covered services*, program changes, how to access services, *primary care provider* assignment, providers, advance directive information, *authorizations*, benefit denials, *member* rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such notices shall include:
    a. Any changes in clinical review criteria; or
    b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
13. A current list of *network providers*.
14. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
15. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, ethnicity, race, , gender, sex, sexual orientation, national origin, religion or disability.
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. They can help *your primary care provider* and other providers understand *your* wishes about *your* health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for *yourself*. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney

c. "Do Not Resuscitate" Orders. *Member*s also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read the entire *contract*.
2. Treat all healthcare professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of *your physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* I.D. card and keep scheduled appointments with *your physician*, and call the *physician*'s office during office hours whenever possible if *you* have a delay or cancellation.
6. Know the name of *your* assigned *primary care provider*. *You* should establish a relationship with *your 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* and/or *your* healthcare professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* healthcare professionals and *physician*.
11. Tell *your* healthcare professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *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 *coinsurance 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.

IMPORTANT INFORMATION

Provider Directory
A listing of *network providers* is available online at Ambetter.sunflowerhealthplan.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 using 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 1-844-518-9505 (TTY/TDD 1-844-546-9713). In order to obtain benefits, *you* must designate a *primary care provider* (PCP) for each *member. We* can help *you* pick a *primary care provider. 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 1-844-518-9505 (TTY/TDD 1-844-546-9713). *We* will help *you* make the appointment.

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

The ID card will show *your* name, *member* ID#, and *copayment amounts* required at the time of service. If *you* do not get *your* ID card within a few weeks after *you* enroll, please call Member Services at 1-844-518-9505 (TTY/TDD 1-844-546-9713). *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.SunflowerHealthPlan.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. Selecting a *Primary Care Provider*.
9. *Deductible* and *Co-payment* Accumulators.
10. Making *your* payment.

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

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. 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 that 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 physician* or service provided by *us*, please contact the *Member* Services Department.

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

DEFINITIONS

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

Wherever used in this policy:

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

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:

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

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

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

Allowed amount (also Eligible Service Expense) is the maximum amount we will pay a physician for a covered service. When a covered service is received from a network physician, 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.

Applied behavior analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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

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

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

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

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

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

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

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

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

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

Center of excellence means a *hospital* that:

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

Claimant is the *member* or *member's authorized* representative who has contacted the plan to file a *grievance* or appeal or who has contacted the Kansas Department of Insurance to file an external review.

Coinsurance is the percentage of covered expenses that must be paid by you after the *deductible*. This percentage is shown on the *schedule of benefits*

Complications of pregnancy means:

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

Contract when *italicized,* refers to this *contract* as issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

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

Cosmetic treatment means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an *injury*, *illness*, or congenital anomaly. *Cosmetic treatment* does not include *reconstructive surgery* when the service is incidental to or follows *surgery* resulting from trauma, infection or other diseases of the involved part, and *reconstructive surgery* because of congenital disease or anomaly of a covered *dependent* child that has resulted in a functional defect.

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

Cost sharing percentage means the percentage of *covered services* that are payable by *us*.

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

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

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

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

Custodial care includes but is not limited to the following:

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

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

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

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

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

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

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

Dependent means *your* lawful *spouse, civil union partner* and/or an *eligible child*, by blood or law, who is under age 26*.*

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

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

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

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

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

It is *your* responsibility to notify the entity with which you enrolled (either the 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 service expense* as determined below.

1. For *network providers*: When a *covered service 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 service* 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 as payment in full (*you* will not be billed for the difference between the negotiated fee and the provider's charge). However, if the provider has not agreed to accept a negotiated fee with *us* as payment in full, the *eligible 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 in-*network* providers for the *covered service*. If there is more than one contracted amount with in-*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 *non-network provider's* charge.

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

c. When a *covered service* is received from a *non-network provider* because there is no *network provider* with appropriate training and experience or because the network is insufficient to meet access standards prescribed by law, 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 accepted by the provider (not to exceed the provider's charge).

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

Emergency means a medical condition manifesting itself by a sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide immediate medical attention would result in:

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

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

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

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

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (USFDA) regulation, regardless of whether the trial is subject to USFDA oversight;
2. An *unproven service;*
3. Subject to USFDA approval, and:
    a. It does not have USFDA approval;
    b. It has USFDA approval only under its Treatment Investigational New Drug regulation or a similar regulation;
    c. It has USFDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a USFDA-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;

ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
iii. Not an *unproven service;* or

d. It has USFDA approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the USFDA or has not been determined through peer reviewed medical literature to treat the medical condition of the *covered person.*

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

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

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

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

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

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

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

Grievance 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 reform or rescind a *contract*;; and
3. Claims practices.

Habilitation or ***Habilitation services*** means health care services that help *you* keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* or *outpatien*t settings.

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

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

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

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

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

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

Hospital means an institution that:

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

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, or a patient is moved 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 member.

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

Injury means accidental bodily damage sustained by a *member* that is the direct cause of the condition for which benefits are provided, independent of disease or body infirmity or any other

cause that occurs while this *contract* is in 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 use, are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

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

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

Loss means an event for which benefits are payable to a *member* under this *contract*. *Expenses* incurred prior to this *contract*'s *effective date* are not covered, however, *expenses* incurred beginning on the *effective date* of insurance under this *contract* are covered.

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 covered 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.

Manipulative therapy means treatment applied to the spine or joint structures to correct vertebral or joint malposition and to eliminate or alleviate somatic dysfunction including, but not limited to, manipulation, myofascial release or soft tissue mobilization. Treatment must demonstrate pain relief and continued improvement in range of motion and function and cannot be performed for maintenance care only. *Manipulative therapy* is not limited to treatment by manual means.

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 service expenses*, as shown in the *schedule of benefits*. After the *maximum out-of-pocket amount* is met for an individual, Ambetter from Sunflower Health Plan 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*.

For family coverage, the family *maximum out-of-pocket* amount can be met with the combination of any one or more *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. Y*our* 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 practitioner includes but is not limited to a *physician*, nurse anesthetist, *physician*'s assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *contract:* rolfer, hypnotist, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *covered person*;
5. Is not *experimental or investigational*;

6. 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;
7. Is no more costly than an alternative *Covered service* that is likely to produce equivalent therapeutic outcome; 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 participating practitioner means a *medical practitioner* who is eligible to receive reimbursement from Medicare for treating Medicare-eligible individuals.

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

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

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

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

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

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

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

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

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

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

Other plan means any plan or policy that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, automobile no-fault or medical pay, 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 means services that 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 contraceptive services means consultations, examinations, and medical services, provided on an *outpatient* basis and related to the use of contraceptive methods to prevent *pregnancy* which has been approved by the U.S. Food and Drug Administration.

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

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

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 he or she is not a *hospital inpatient.*

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

Post-service claim means any claim for benefits for medical care or treatment to which the terms of the plan do not condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining the medical care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Scalp hair prostheses means artificial substitutes for scalp hair that are made specifically for a specific *member*.

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 Kansas to sell and market *our* health plans. This is where the majority of *our* Participating Providers are located where *you* will receive all of *your* healthcare services and supplies. *You* can receive precise *service area* boundaries from *our* website or our Member Services department.

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

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

Spouse means the person to whom *you* are lawfully married.

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

Substance use 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 Diagnostic and Statistical Manual of Mental Disorders or the most recent edition of the International Classification of Diseases.

Surgery or ***surgical procedure*** means:

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

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 months or less to live.

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

Unproven service(s) means services, including medications that are determined not to be effective for treatment of the medical condition, and/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, healthcare services, procedures, or settings. Areas of review may include ambulatory review, prospective review, second opinion, certification, concurrent review, *case management*, discharge planning, or retrospective review.

DEPENDENT MEMBER COVERAGE

Dependent Eligibility
Your dependents become eligible for insurance on the latter of:

1. The date *you* became covered under this *contract;* or
2. The date of marriage to add a *spouse*; *or*
3. The date of an eligible newborn's birth; or
4. The date that an adopted child is placed with a *covered person* for the purposes of adoption or a *covered person* assumes total or partial financial support of the child.

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

Coverage for a Newborn Child
An *eligible child* born to a *covered person* will be covered from the time of birth until the 31st day after its birth. Each type of covered service incurred by the newborn child will be subject to the cost sharing amount listed in the Schedule of Benefits.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth. If notice of the newborn is given to *us* by the Marketplace within the 31 days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 days after the birth of the child. If notice is given by the Marketplace within 60 days of the birth of the child, the *contract* may not deny coverage of the child due to failure to notify *us* of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st day after its birth, unless *we* have received notice from the entity that *you* have enrolled (either the Marketplace or *us*).

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

The child will be covered on the same basis as any other *dependent*.

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

As used in this provision, *"placement"* means the date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption pursuant to an adoption proceeding.

Adding Other Dependents

If *you* are enrolled in an off-marketplace 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 member's effective date* of coverage and ID Cards for the added *dependent*.

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

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *contract*;
2. The primary *member* residing outside the *service area* or moving permanently outside the *service area* of this plan;
3. The date of a *member's* death;
4. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *contract* or the date that we have not received timely premium payments in accordance with the terms of this *contract*;
5. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or
6. The date of termination that the Marketplace provides *us* upon *your* request of cancellation to the Marketplace, or if *you* enrolled directly with *us*, the date *we* receive a request from *you* to terminate this contract, or any later date stated in *your* request.

For *Dependents*
A *dependent* will cease to be a *member* at the end of the premium period in which he or she ceases to be *your dependent member*. For *eligible children*, coverage will terminate the thirty-first of December the year that the dependent turns 26 years of age. All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*.

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

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

Open Enrollment
There will be an open enrollment period for coverage on the Health Insurance Marketplace. The initial open enrollment period begins November 1, 2019 through December 15, 2019. *Qualified individuals* who enroll prior to December 15, 2019 will have an *effective date* of coverage on January 1, 2020.

If *you* have material modifications (examples include a change in life event (marriage, death) or family status), or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace at www.healthcare.gov or 1-800-318-2596. If you enrolled directly with *us* contact Member Services at 1-844-518-9505 (TTY/TDD 1-844-546-9713).

Special and Limited Enrollment
A *Qualified individual* has 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:

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

2. A *Qualified individual* 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 1 or more days during the 60 days preceding the date of marriage.
3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
4. An individual who is no longer incarcerated or whose incarceration is pending the disposition of charges;
5. A *Qualified* individual's enrollment or non-enrollment in a *qualified health plan* is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace or HHS, or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
6. An enrollee adequately demonstrates to the Health Insurance Marketplace that the *qualified health plan* in which he or she is enrolled substantially violated a material provision of its *contract* in relation to the enrollee's decision to purchase the qualified health plan based on plan benefits, service area or premium;
7. 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*;
8. A *Qualified individual* or enrollee gains access to a new *qualified health plan* as a result of a permanent move;
9. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
10. 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
11. A *Qualified individual* or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide.
12. 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;
13. 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
14. 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 birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance payments of the premium tax credit* and *cost-*

sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where a *qualified individual* loses minimum essential coverage, the *effective date* is the first day of the following month.

The Health Insurance Marketplace may provide a coverage *effective date* for a *qualified individual* earlier than specified in the paragraphs above, provided that either:

1. The *qualified individual* has not been determined eligible for *advanced payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *qualified individual* pays the entire premium for the first partial month of coverage as well as all *cost sharing*, thereby waiving the benefit of *advanced payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month.

PREMIUMS

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

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

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 credit*s on behalf of the *member* from the Department of the Treasury, and will return the *advanced premium tax credit*s on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above. A *member* is not eligible to re-enroll once terminated, unless a *member* has a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

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

Third Party Payment of Premiums or Cost Sharing
Ambetter requires each policy holder 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; or
4. Family members.
5. Private, not-for-profit foundations which have no incentive for financial gain, no financial relationship, or affiliation with providers of covered services and supplies on behalf of members, where eligibility is determined based on defined criteria without regard to health status and where payments are made in advance for a coverage period from the effective date of eligibility through the remainder of the calendar year.

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.

Reinstatement
If *your contract* lapses due to nonpayment of premium, it may be reinstated provided:

1. *We* receive from *you* a written application for reinstatement within one year after the date coverage lapsed; and
2. The written application for reinstatement is accompanied by the required premium payment.

Premium accepted for reinstatement may be applied to a period for which premium had not been paid. The period for which back premium may be required will not begin more than 60 days before the date of reinstatement.

The *Rescission*s provision will apply to statements made on the reinstatement application, based on the date of reinstatement.

In all other respects, *you* and *we* will have the same rights as before *your contract* lapsed.

Misstatement of Age
If a *member's* age has been misstated, Member's premium may be adjusted 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 60 days of the change. As a result *your* premium may change and *you* may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information.

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

COST SHARING FEATURES

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

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

Copayments
A copayment is 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 percentage is your share of the cost of a service. Members may be required to pay a coinsurance in addition to any applicable deductible amount(s) due for a covered service or supply. Coinsurance amounts do not apply toward the deductible, but do apply toward your Maximum Out-of-Pocket amount.

Deductible
The *deductible amount* means the amount of *covered service expenses* that must be paid by all *members* before any benefits are payable. If on a family plan, if one *member* of the family meets his or her *deductible*, benefits for that *member* will be paid. The *deductible amoun*t does not include any *copayment amount* or *coinsurance* amount. Not all *covered service expenses* are subject to the *deductible* amount. See *your schedule of benefits* for more details.

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

Refer to your Schedule of Benefits for Coinsurance Percentage and Other Limitations
The amount payable will be subject to:

1. Any specific benefit limits stated in the *contract*;
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*.

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* and *coinsurance percentage*, *you* are responsible for the difference between the *eligible expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible expense* will not apply to *your deductible amount* or out-of-pocket maximum.

ACCESS TO CARE

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

Your primary care provider will be responsible for coordinating all covered health services with other *network providers. You* do not need a referral from *your primary care provider* for mental or behavioral health services, obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist.

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

Network Availability
Your network is subject to change. The most current *network* may be found online at our website or by contacting *us* at the number shown on *your* identification card. A *network* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *contract* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

In the event your network provider is terminated from the network for any reason, continuation of care for a period up to 90 days may be provided. The continuation of such care is medically necessary and where the member has special circumstances such as a disability, a life threatening illness or is in the third trimester of pregnancy.

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

MAJOR MEDICAL EXPENSE BENEFITS

The Plan provides coverage for healthcare services for a member and/or dependents. Some services require preauthorization.

Copayment amounts must be paid to your network provider at the time you receive services.

All Covered services are subject to conditions, exclusions, limitations, terms and provision of this policy. Covered service must be medically necessary and not experimental or investigational.

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

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

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

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 of the 50 United States and the District of Columbia;
    b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
    c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States; or
4. Ambulance services provided for a *member's* comfort or convenience.
5. Non-*emergency* transportation excluding ambulances (for example- transport van, taxi).

***Autism Spectrum Disorder* Expense Benefit**
Covered service expenses for *autism spectrum disorder* include *coverage* for the diagnosis of *autism spectrum disorder*s and for the *treatment of autism spectrum disorders*.

1. Upon request by *us*, a *provider* of treatment for *autism spectrum disorder*s shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is *medically necessary* and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable

progress, *we* may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

2. When making a determination of medical necessity for a treatment modality for *autism spectrum disorder*s, *we* will make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under this *contract*, including an appeals process. During the appeals process, any challenge to *medical necessity* must be viewed as reasonable only if the review includes a *physician* with expertise in the most current and effective treatment modalities for *autism spectrum disorder*s. Coverage for *medically necessary* early intervention services must be delivered by certified early intervention specialists.
3. Habilitation services, for *member*s with a diagnosis of *autism spectrum disorder*, at a minimum shall include: *applied behavior analysis* that is intended to develop, maintain, and restore the functioning of an individual.

Spinal Manipulation Services

Chiropractic Services are covered when a Participating provider finds that the 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 contract, including deductible amount and cost sharing percentage provisions.

Clinical Trials for Cancer and Other Life-Threatening Illnesses

Covered service expenses for the routine patient care costs incurred by a *member* enrolled in an approved clinical trial related to cancer, including leukemia, lymphoma, and bone marrow stem cell disorders, or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, if the *member's physician* determines that:

1. There is no clearly superior non-investigational treatment alternative; and
2. Available clinical or preclinical data provide a reasonable expectation that the treatment provided in the clinical trial will be at least as effective as any non-investigational alternative.

Covered service expenses include the costs of:

1. Prevention, diagnosis, treatment, and palliative care of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted;
2. Medical care for an approved clinical trial related to cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, that would otherwise be covered under a healthcare insurance plan if the medical care were not in connection with an approved clinical trial;
3. Items or services necessary to provide an investigational item or service;
4. The diagnosis or treatment of complications;
5. A drug or device approved by the United States Food and Drug Administration without regard to whether the United States Food and Drug Administration approved the drug or device for use in treating a patient's particular condition, but only to the extent that the drug or device is not paid for by the manufacturer, distributor, or provider of the drug or device;
6. Services necessary to administer a drug or device under evaluation in the clinical trial; and
7. Transportation for the patient that is primarily for and essential to the medical care.

Covered service expenses do not include:

1. A drug or device that is associated with the clinical trial that has not been approved by the United States Food and Drug Administration;
2. Housing, companion expenses, or other nonclinical expenses associated with the clinical trial;
3. An item or service provided solely to satisfy data collection and analysis and not used in the clinical management of the patient;
4. An item or service excluded from coverage under the patient's healthcare insurance plan; and
5. An item or service paid for or customarily paid for through grants or other funding.

The coverage required by this section is subject to the standard *contract* provisions applicable to other benefits, including *deductible* and *coinsurance*.

Vision Benefits – Adults 19 years of age or older

Coverage for vision services is provided for adults, age 19 and older, from a network provider.

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.SunflowerHealthPlan.com or call Member Services.

Services not covered:

1. Visual therapy;
2. Low vision services and hardware for adults; and
3. Non-network care without prior authorization.

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. Preventative and Diagnostic (Routine Dental Services)—Class 1 benefits include:

a. Routine cleanings;

b. Oral exams;

c. X-rays – bite-wing, full-mouth and panoramic film;

d. Topical fluoride application.

2. Minor Restorative (Basic Dental Care)— Class 2 benefits include:

a. Minor restorative – metal and resin based filings;
b. Endodontic therapy;
c. Periodontics – scaling, root planning and periodontal maintenance;
d. Simple extractions;
e. Prosthodontics – relines, rebase, adjustment and repairs.
3. Major Restorative (Major Dental Care)—Class 3 benefits include:
a. Crowns and bridges;
b. Dentures;
c. More complex extractions and surgical services.

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.SunflowerHealthPlan.com or call Member Services.

Services not covered:
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;
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).

Diabetic Care
Benefits are available for *medically necessary* services and supplies used in the treatment of diabetes.

Covered service expenses include, but are not limited to: exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies, glucose strips for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication;

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

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

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

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

Durable Medical Equipment, Prosthetics, and Orthotic Devices
The supplies, equipment and appliances described below are covered services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is *medically necessary* in your situation or needed to treat your condition, reimbursement will be based on the maximum allowable amount for a standard item that is a covered service, serves the same purpose, and is *medically necessary*. Any expense that exceeds the maximum allowable amount for the standard item which is a covered service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition. Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

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

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

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

Benefits for repairs and replacement do not include the following:

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

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

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

Covered services may include, but are not limited to:

1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for IV fluids and medicine.
5. Glucometer.
6. Tracheotomy tube.
7. Cardiac, neonatal and sleep apnea monitors.
8. Augmentive communication devices are covered when we approve based on the *member's* condition.

Exclusions:
Non-covered items may include but are not limited to:

1. Air conditioners.
2. Ice bags/coldpack pump.
3. Raised toilet seats.
4. Rental of equipment if the *member* is in a facility that is expected to provide such equipment.
5. Translift chairs.
6. Treadmill exerciser.
7. Tub chair used in shower.

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

Covered services may include, but are not limited to:

1. Allergy serum extracts.
2. Chem strips, glucometer, lancets.
3. Clinitest.
4. Needles/syringes.
5. Ostomy bags and supplies except charges such as those made by a pharmacy for purposes of a fitting are not Covered Services.

Exclusions:
Non Covered Services include but are not limited to:

1. Adhesive tape, band aids, cotton tipped applicators.
2. Arch supports.
3. Doughnut cushions.
4. Hot packs, ice bags.
5. Vitamins (except as provided for under Preventive benefits).
6. Med-injectors.
7. Items usually stocked in the home for general use like band aids, thermometers, and petroleum jelly.

Prosthetics

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

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

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

Covered Services may include, but are not limited to:

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

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

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

Orthotic devices

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

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

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

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

Exclusions:

Non-covered services include but are not limited to:

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

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

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

1. *Covered expenses* available to a *covered person* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision;
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must 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*, *rehabilitation facility*, or *extended care facility* for:
    a. Daily room and board and nursing services;
    b. Diagnostic testing; and
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration;
4. *Covered expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners.*

5. *Habilitation* and *Rehabilitation* Services are limited to 90 days per benefit period (Occupational Therapy, Physical Therapy and Speech Therapy).
6. Coverage for Cardiac Rehabilitation.

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*.

Definition:
As used in this provision, *"provider facility"* means a *hospital, rehabilitation facility*, or *extended care facility*.

Home Health Care Expense Benefits
Covered Services and supplies for home health care are covered when your physician indicates you are not able to travel for appointments in a medical office. Coverage is provided for medically necessary in-network care provided at the member's home and includes the following:
1. *Home health aide services*;
2. Services of a private duty registered nurse rendered on an *outpatient* basis;
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care;*
4. I.V. medication and pain medication;
5. *Necessary medical supplies*; and
6. Rental of the *durable medical equipment;* and
7. Sleep studies.

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

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

Hospice Care Expense Benefits
Hospice care benefits are allowable for a *terminally ill covered person* receiving *medically necessary* care under a *hospice care program*. *Covered services* include:
1. Room and board in a *hospice* while the *covered person* is an *inpatient;*
2. Occupational therapy;
3. Speech-language therapy;
4. The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *policy* if the *covered person* had been confined in a *hospital;*
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management;
6. Counseling the *covered person* regarding his or her *terminal illness;*
7. *Terminal illness counseling* of members of the *covered person's immediate family*; and

8. *Bereavement counseling*.

Benefits for *hospice inpatient,* home or *outpatient* care are available to a *terminally ill member* for one continuous period up to 180 days in a *member's* lifetime. For each day the *member* is confined in a *hospice,* benefits for room and board will not exceed the most common semiprivate room rate of the *hospital* or nursing home with which the *hospice* is associated.

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 *member*s from the duties of caring for a *covered person* under *hospice* care. Respite days that are applied toward the *deductible amount* are considered benefits provided and shall apply against any maximum benefit limit for these services.

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

1. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
2. Daily room and board and nursing services while confined in an *intensive care unit*.
3. *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, which are routinely provided by the *hospital* for use only while *you* are *inpatient.*
6. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See *your schedule of benefits* for limitations.

Infertility Services
Covered services for infertility treatment are limited to diagnostic testing to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy and semen analysis. Benefits are included to treat the underlying medical conditions that cause infertility (such as endometriosis, obstructed fallopian tubes and hormone deficiency).

Mammography Coverage
Breast cancer screening mammography is provided annually or as prescribed by your *physician* or *medical practitioner.*

Mental Health and Substance Use Disorder Benefits

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

Mental health services will be provided on an *inpatient* and *outpatient* basis and include treatable *mental health disorder*s. These disorders affect the *member*'s ability to cope with the requirements

of daily living. If *you* need mental health and/or substance use disorder treatment, *you* may choose any provider participating in *our* behavioral health *network* and do not need a referral from *your* PCP in order to initiate treatment. *Deductible amounts*, *copayment* or *coinsurance* amounts and treatment limits for covered mental health and substance use disorder benefits will be applied in the same manner as physical health service benefits.

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

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

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

Covered services for inpatient hospital mental or behavioral health services only when the services are for the diagnosis or treatment of Mental Disorders; and must result in clinically significant distress or impairment of mental, emotional, or behavioral functioning. For the detoxification and medical management of withdrawal symptoms associated with substance use.

Outpatient

1. Partial Hospitalization Program (PHP)
2. Intensive *Outpatient* Program (IOP);
3. Mental Health Day treatment;
4. Evaluation and assessment for mental health and substance use;
5. Traditional outpatient services, including individual and group therapy services;
6. Medication management services;
7. Medication Assisted Treatment- combines behavioral therapy and medications to treat substance use disorders;
8. *Outpatient* detoxification programs;
9. Psychological and Neuropsychological testing and assessment;
10. Applied Behavioral Analysis for treatment of Autism;
11. Telehealth; and
12. Electroconvulsive Therapy (ECT).
13. Transcranial Magnetic Stimulation

Covered services for outpatient mental or behavioral health services only when the services are for the diagnosis or treatment of Mental Disorders; and the treatment of substance use/chemical dependency.

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

Services for conditions the DSM identifies as something other than a mental disorder will not be covered.

Medical Foods
We cover medical foods and formulas when medically necessary for the treatment of Phenylketonuria (PKU).

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. For services received for urgent care, including facility charges at an *urgent care center*;
3. Made by a *physician* for professional services, including *surgery;*
4. Made by an assistant surgeon*;*
5. For the professional services of a *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;
8. For chemotherapy and radiation therapy or treatment;
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 his or her natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any *injury* as a result of chewing;
    c. Treatment made necessary due to *injury* to the jaw and oral structures other than teeth are covered without time limit;
13. For reconstructive breast *surgery* charges as a result of a partial or total mastectomy for breast cancer, if the patient elects reconstruction and in the manner chosen by the patient and the *physician*. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic device*s necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas;
14. For *surgery*, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint, as well as removable appliances for TMJ repositioning and related *surgery*, medical care, and diagnostic services;

15. For *medically necessary manipulative therapy* treatment on an *outpatient* basis only. See the *schedule of benefits* for benefit levels or additional limits. *Covered expenses* are subject to all other terms and conditions of the *policy,* including *deductible* and *coinsurance percentage* provisions;
16. For pulse oximetry screening on a newborn;
17. For the following types of tissue transplants:
    a. Cornea transplants;
    b. Artery or vein grafts;
    c. Heart valve grafts;
    d. Prosthetic tissue replacement, including joint replacements;
    e. Implantable prosthetic lenses, in connection with cataracts.
18. For dental procedure coverage for the *medically necessary* facility charges and administration of general anesthesia administered by a licensed anesthesiologist or anesthetist for dental procedures performed on a *member* who:
    a. is a child under the age of 6 who is determined by a licensed dentist in conjunction with a licensed *primary care provider* to have a dental condition of significant dental complexity which requires certain dental procedures to be performed in a surgical day care facility or *hospital* setting; or
    b. is a person who has exceptional medical circumstances or a developmental disability as determined by a licensed *primary care provider* which place the person at serious risk;
19. For *outpatient contraceptive services* for any type of drug or device for contraception, which is lawfully prescribed and has been approved by the FDA. Additionally, coverage is required for any *outpatient* services related to the use of a drug or device intended to prevent *pregnancy*;
20. For the provision of nonprescription enteral formulas and food products required for *members* with inherited diseases of amino acids and organic acids. Such coverage shall be provided when the prescribing *physician* has issued a written order stating that the enteral formula or food product is *medically necessary* and is the least restrictive and most cost effective means for meeting the needs of the *member*. Coverage for inherited diseases of amino acids and organic acids shall, in addition to the enteral formula, include food products modified to be low protein;
21. For scalp hair prosthesis expenses for hair loss suffered as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia, or permanent loss of scalp hair due to *injury*. Such coverage, shall be subject to a written recommendation by the treating *physician* stating that the hair prosthesis is a medical necessity;
22. For children's early intervention therapy for expenses arising from the services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists, and clinical social workers working with children from birth to 36 months of age with an identified developmental disability and/or delay as long as the providing therapist receives a referral from the child's *primary care provider* if applicable;
23. For *medically necessary* diagnostic and laboratory and x-ray tests;
24. For *telehealth* for *covered services* provided within the scope of practice of a *physician* or other healthcare provider as a method of delivery of medical care by which a *member* shall receive medical services from a healthcare provider without in-person contact with the provider;
25. For injections, including allergy injections;
26. For *medically necessary* oral *surgery*, including the following:
    a. Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.

b. Orthognathic *surgery* for a physical abnormality that prevents normal function of the upper and/or lower jaw bone and is *medically necessary* to attain functional capacity of the affected part.
c. Oral / surgical correction of accidental injuries as indicated in the "Dental Services" section.
d. Surgical services as described in the "Temporomandibular Joint (TMJ) and Craniomandibular Joint Services" section.
e. Treatment of non-dental lesions, such as removal of tumors and biopsies.
f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
g. Surgical procedures that are *medically necessary* to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.
h. *Reconstructive surgery.*

27. For *medically necessary* genetic blood tests; and
28. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
29. Coverage for services related to diagnosis, treatment and management of osteoporosis when such services are provided by a medical *provider* licensed to practice medicine and *surgery* in Kansas, for *covered persons* with a condition or medical history for which bone mass measurement is *medically necessary* for such individual.

Outpatient Medical Supplies Expense Benefits

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

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs but not the replacement thereof, unless required by a physical change in the *covered person* and the item cannot be modified. If more than one *prosthetic device* can meet a *covered person's* functional needs, only the charge for the most cost effective *prosthetic device* will be considered a *covered expense*;
2. For one pair of foot orthotics per *covered person*;
3. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator;
4. For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint *surgery*;
5. Infusion therapy;
6. For one pair of eyeglasses or contact lenses per *member* following a cataract *surgery*, or if the lens of *your* eye has been surgically removed or is congenitally absent; and
7. For any other use of a drug approved by the United States Food and Drug Administration when the drug has not been approved by the United States Food and Drug Administration for the treatment of the particular indication for which the drug has been prescribed, provided such drug is recognized for treatment of such indication in one of the standard reference compendia or in the medical literature as recommended by current American Medical Association (AMA) policies. Any coverage of a drug required shall also include *medically necessary* services associated with the administration of the drug. This benefit shall not be construed to require:
    a. Coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;
    b. Coverage for experimental or investigational drugs not approved for any indication by the FDA; and
    c. Reimbursement or coverage for any drug not included on the drug formulary or list of covered drugs specified in this *contract.*

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

Other maternity benefits which may require prior authorization include:

a. Outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, and childbirth classes.
b. Physician Home Visits and Office Services.
c. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
a. Complications of pregnancy.
d. Hospital stays for other medically necessary reasons associated with maternity care.

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

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

Note: This provision does not amend the contract to restrict any terms, limits, or conditions that may otherwise apply to Surrogates and children born from Surrogates. Please see General Limitations and Exclusions.

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

Newborns' and Mothers' Health Protection Act Statement of Rights
If expenses for *hospital* confinement in connection with childbirth are otherwise included as *covered service 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 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, *we* may provide benefits for *covered service 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.

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 *contract* to restrict any terms, limits, or conditions that may otherwise apply to *covered service expenses* for childbirth.

Prescription Drug Expense Benefits

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

1. A *prescription drug; and*
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician.*
3. 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; and
4. Self-administered human growth hormones to treat children with short stature who have an absolute deficiency in natural growth hormone. Benefits are also available to treat children with short stature who have chronic renal insufficiency and who do not have a functioning renal transplant.
5. Orally administered anti-cancer medication

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

See the *schedule of benefits* for benefit levels or additional limits.

Covered *prescription drugs*, which are not subject to utilization management, prior *authorization*, or pre-certification requirements, and are considered maintenance, are covered up-to-90-day supply at retail pharmacies within *our network*. Controlled substances as identified by the United States Drug Enforcement Administration are exempt from this section. The *prescription drugs* received in a 90-day supply may be subject to co-payments, *coinsurance deductible*s, or other *member cost shares*.

The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her *physician. Experimental or investigational treatment* drugs will be covered as defined.

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.

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

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

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

If *we* grant an external exception review of a standard exception or step therapy protocol exception request, *we* will provide coverage of the non-formulary drug or the drug that is the subject of the protocol exception for the duration of the prescription. If *we* grant an external exception review of an expedited exception request, *we* will provide coverage of the non-formulary drug or the drug that is the subject of the protocol exception for the duration of the exigency.

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.*

Non-Covered Services and Exclusions:
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 by the Affordable Care Act;
3. For medication received while the *covered person* is a patient at an institution that has a facility for dispensing pharmaceuticals;
4. For a refill dispensed more than 12 months from the date of a *physician's* order;

5. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs;
6. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary;
7. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs;
8. For any drug that we identify as therapeutic duplication through the drug *utilization review* program;
9. For more than a 31-day supply when dispensed in any one prescription or refill, or for maintenance drugs up to 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply *network*;
10. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
11. Off-label use, except as required by law or as expressly approved by us;
12. Foreign Prescription Medications, except those associated with an *Emergency* Medical Condition while *you* are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States;
13. 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; or
14. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
15. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventative treatment is related to member's vacation for out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
16. Medications used for cosmetic purposes.
17. 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.
18. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.

Drug Discount, Coupon or Copay Card

Cost sharing paid on *your* behalf for any prescription drugs obtained by *you* through the use of a *drug discount, coupon, or copay card* provided by a prescription drug manufacturer will not apply toward *your* plan deductible or *your* maximum out of pocket for any brand name drug that is available as a generic version.

Pediatric Vision Benefits – Children under the age of 19

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

1. Routine ophthalmological exam
    a. Refraction;
    b. Dilation;
    c. Contact lens fitting.

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

Please refer to your Schedule of Benefits for a detailed list of cost sharing, annual maximum and appropriate service limitations. To see which vision providers are part of the network, please visit Ambetter.SunflowerHealthPlan.com or call Member Services.
Services not covered:
1. Visual therapy;
2. Two pair of glasses as a substitute for bifocals;
3. Non-network care without prior authorization.

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

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
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; and
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. All FDA-approved contraception methods (identified on www.fda.gov) are approved for *member*s without *cost sharing* as required under the Affordable Care Act. *Member*s 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*; and

6. 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* and *coinsurance* provisions under the *policy* when the services are provided by a *network provider.* Benefits include coverage for smoking cessation counseling and related *prescription drug*s.

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 *deductible*s and *coinsurance* provisions to services when a *covered person* chooses not to use a high value service that is otherwise exempt from *deductible*s and *coinsurance* provisions when received from a *network provider*.

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

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

Transplant Service Expense Benefits

Covered expenses for transplant expenses:
Transplants are a covered benefit when a member is accepted as a transplant candidate and pre-authorized in accordance with this contract. Transplant services must be provided by an in-network provider and facility, and meet other medical criteria as set by medical management policy and the medical providers performing the transplant. If *we* determine that a *member* 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. The transplant itself, not including the acquisition cost for the organ or bone marrow except at a *Center of Excellence*;
7. Coverage for laboratory fee expenses up to $150 arising from human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for utilization in bone marrow transplantation. The testing shall be performed in a facility that is accredited by the American Association of Blood Banks or its successors, or the College of American Pathologists, or its successors, or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists, and is licensed under the Clinical Laboratory Improvement Act of 1967, 42 U.S.C. section 263a, as amended. At the time of the new testing, the *member* tested shall complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program. Pursuant to RSA 451:6-m, II., the testing facility should not *balance bill you* for any remaining portion of the laboratory fee expenses; and
8. Post-transplant follow-up.

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

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

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

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

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

1. For 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 not included under this provision as a *medically necessary* transplant; and

7. For a *medically necessary* transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (USFDA) regulation, regardless of whether the trial is subject to USFDA oversight.

Limitations on Transplant Expenses Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Care Outside the United States.
Treatment for care received outside the United States, *emergency* and non-emergency care, will be covered on the same basis as care received in the United States, subject to the terms of the *policy*.

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

Urgent Care Service Benefits

Urgent Care services include Medically Necessary services by in-network Providers and services provided at an Urgent Care Center including Facility costs and supplies. Care that is needed after a Primary Care Provider's normal business hours is also considered to be Urgent Care. Your zero cost sharing Preventive Care Benefits may not be used at an Urgent Care Center.

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

Social Determinants of Health Supplemental Benefits

Social determinants of health supplemental benefits and services may be offered to enrollees to remove barriers to accessing health services and improve overall health outcomes. These are benefits and services that we may make available in connection with this contract. The benefits and services provided may include transportation to health services, assistance with childcare, access to healthy meals, and other relevant services based on need. The benefits are available as long as coverage remains active, unless changed by us. Upon termination of coverage, the benefits are no

longer available. All enrollees are automatically eligible for the benefits upon obtaining coverage. The services are optional, and the benefits are made available at no additional cost to the enrollees. The benefits and services available at any given time are made part of this contract by this reference and are subject to change by us through an update to information available on our website or by contacting us.

Social determinants of health benefits and services may be offered to enrollees through the "My Health Pays" wellness program and through local health plan websites. Enrollees may receive notifications about available benefits and services through emails from local health plans and through the "My Health Pays" notification system. To inquire about these benefits and services or other benefits available, you may visit our website at Ambetter.SunflowerHealthplan.com or by contacting Member Services at 1-844-518-9505 (1-844-546-9713).

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.SunflowerHealthplan.com or by contacting Member Services at 1-844-518-9505 (1-844-546-9713). 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.

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*.

Prior Authorization must be obtained for the following services, except for Urgent Care or Emergency Services. This list is not exhaustive, to confirm if a specific service requires Prior Authorization, please contact Member Services.

- Non-Emergency Health Care Services provided by Non-Network Providers;
- Reconstructive procedures;
- Diagnostic Tests such as specialized labs, procedures and high technology imaging;
- Injectable drugs and medications;
- Inpatient Health Care Services;
- Specific surgical procedures;
- Nutritional supplements;
- Pain management services; and
- Transplant services.

For services or supplies that require *prior authorization*, as shown on the *schedule of benefits*, *you* must obtain *authorizatio*n from *us* before the *covered person:*

1. Receives a service or supply from a *non-network provider;*
2. Is admitted into a *network* facility by a *non-network provider;* or
3. Receives a service or supply from a *network provider* to which the *covered person* was referred by a *non-network provider.*

Prior Authorization requests must be received by telephone, eFax, or provider web portal as follows:

1. At least 5 days prior to an elective admission as an *inpatient* in a *hospital*, extended care or *rehabilitation* facility, or *hospice* facility.
2. At least 30 days prior to the initial evaluation for organ transplant services.
3. At least 30 days prior to receiving clinical trial services.
4. Within 24 hours of any *inpatient* admission, including emergent inpatient admissions. a
5. At least 5 days prior to the start of home healthcare except those members needing home health care after hospital discharge.

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

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

Except for *medical emergencies*, *prior authorization* must be obtained before services are rendered or expenses are *incurred*.

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

Failure to Obtain Prior Authorization
Failure to comply with the *prior authorization* requirements will result in benefits being reduced. Please see the *policy schedule of benefits* for specific details.

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.*

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

HOSPITAL BASED PROVIDERS
When receiving care at an Ambetter participating *hospital* it is possible that some *hospital*-based providers (for example, anesthesiologists, radiologists, pathologists) may not be under contract with Ambetter as participating providers. These providers who are not contracted for Ambetter 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 healthcare services may be or have been provided to *you* at a healthcare facility that is a *member* of the provider network used by Ambetter, the other professional services may be or have been provided at or through the facility by physicians and other medical practitioners (for example, anesthesiologists, radiologists, pathologists) who are not *member*s 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 by a member of 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 *physician;* and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness,* or covered under the Preventive Care Expense Benefits provision.

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*;
2. For any portion of the charges that are in excess of the *eligible expense;*
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*;
4. For cosmetic breast reduction or augmentation except for the Medically Necessary treatment of Gender Dysphoria;
5. For vasectomies, and reversal of sterilization and vasectomies;
6. For abortion unless the life of the mother would be endangered if the fetus were carried to term;
7. For artificial insemination (AI), assisted reproductive technology(ART) procedures or the diagnostic tests and drugs to support AI or ART procedures;
8. For expenses for television, telephone, or expenses for other persons;
9. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions;
10. For telephone consultations, except those meeting the definition of telehealth services, or for failure to keep a scheduled appointment.
11. For stand-by availability of a *medical practitioner* when no treatment is rendered;
12. 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;
13. 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;
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, *hearing aid*s, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the *policy*;
20. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.
21. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of 90 consecutive days;
22. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *covered person* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *covered person's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *covered person's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency;
23. As a result of:
    a. An *injury* or *illness* caused by any act of declared or undeclared war; or
    b. The *covered person* taking part in a riot;
24. For or related to surrogate parenting;
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. For the following miscellaneous items, unless specifically described in this *contract*: artificial Insemination except where required by federal or state law; care or complications resulting from non-*covered service expenses*; chelating agents; domiciliary care; food and food supplements; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; skilled nursing facilities; 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;
29. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment;
30. 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; and

31. Mental Health Services are excluded:
    a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless a Plan Physician determines such evaluation to be Medically Necessary.
    b. When ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless a Plan Physician determines such Services to be Medically Necessary.
    c. Court-ordered testing and testing for ability, aptitude, intelligence or interest.
    d. Services which are custodial or residential in nature.
32. Surrogacy Arrangement. Health care services, including supplies and medication, to a Surrogate, including a Member acting as a Surrogate or utilizing the services of a Surrogate who may or may not be a Member, and any child born as a result of a Surrogacy Arrangement. This exclusion applies to all health care services, supplies and medication to a Surrogate including, but not limited to:
    (a) Prenatal care;
    (b) Intrapartum care (or care provided during delivery and childbirth);
    (c) Postpartum care (or care for the Surrogate following childbirth);
    (d) Mental Health Services related to the Surrogacy Arrangement;
    (e) Expenses relating to donor semen, including collection and preparation for implantation;
    (f) Donor gamete or embryos or storage of same relating to a Surrogacy Arrangement;
    (g) Use of frozen gamete or embryos to achieve future conception in a Surrogacy Arrangement;
    (h) Preimplantation genetic diagnosis relating to a Surrogacy Arrangement;
    (i) Any complications of the child or Surrogate resulting from the pregnancy; or
    (j) Any other health care services, supplies and medication relating to a Surrogacy Arrangement.
    Any and all health care services, supplies or medication provided to any child birthed by a Surrogate as a result of a Surrogacy Arrangement are also excluded, except where the child is the adoptive child of insureds possessing an active policy with us and/ or the child possesses an active policy with us at the time of birth.

TERMINATION

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date *we* receive a request from *you* to terminate this *contract,* or any later date stated in *your* request, or if *you* are enrolled through the Marketplace, the date of termination that the Marketplace provides us upon *your* request of cancellation to the Marketplace.
3. For a Dependent Child Reaching the Limiting Age of 26, Coverage under this contract, for a Dependent Child, will terminate at 11:59 p.m. on the last day of the year in which the Dependent Child reaches the limiting age of 26.
4. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision.
5. The date of *your* death, if *you* are the only *member* on this *contract*.
6. The date *your* eligibility for insurance under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.
7. The date *your* eligibility for coverage under this Contract ceases as determined by the Marketplace.

If there are other *members* covered under this *contract*, it may be continued after *your* death:

1. By *your spouse*, if a *member;* otherwise
2. By the youngest child who is a *member.*

This *contract* will be changed and *your spouse* or youngest child will replace *you* as the primary *member*. A proper adjustment will be made in the premium required for this *contract* to be continued. *We* will also refund any premium paid and not earned due to *your* death. The refund will be based on a pro-rata basis.

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

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

180-Day Notice:
If *we* discontinue offering and refuse to renew all individual 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 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.

Notification Requirements
It is the responsibility of *you* or *your* former *spouse* to notify the Marketplace or *us* within 31 days of *your* legal divorce.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans does not exceed 100% of the total allowable expense.

DEFINITIONS

1) A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan includes:

a) Group insurance contracts and subscriber contracts;
b) Uninsured arrangements of group or group-type coverage;
c) Group coverage through closed panel plans;
d) Group-type contracts;
e) The medical care components of long-term care contracts, such as skilled nursing care;
f) Medicare or other governmental benefits, as permitted by law, except as provided in Paragraph (4) (h) of this section. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program; and
g) Group and nongroup insurance contracts and subscriber contract that pay or reimburse for the cost of dental care.
h) Nongroup insurance contracts issued on or after January 1, 2014.
i) Nongroup coverage through closed panel plans issued on or after January 1, 2014.

Plan does not include:

a) Hospital indemnity coverage benefits or other fixed indemnity coverage;
b) Accident only coverage;
c) Specified disease or specified accident coverage;
d) Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
e) Medicare supplement policies;
f) A state plan under Medicaid; or
g) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan

Each contract for coverage under (1) or (2) of Paragraph A is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

2) This plan means, in a COB provision, the part of the contract providing the health care benefits

to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

3) The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.

   When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total allowable expense.

4) Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, 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) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

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

   c) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

5) Closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

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

ORDER OF BENEFIT DETERMINATION RULES

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

A. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other plan.

B. (1) Except as provided in Paragraph B (2) a plan that does not contain a coordination of benefits provision that is consistent with K.A.R. 40-4-34 is always primary unless the provisions of both plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. These types of situations include major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each plan determines its order of benefits using the first of the following rules that apply:

(1) 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.

(2) 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:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(b) For a dependent child whose parents are divorced or separated or not

living together, whether or not they have ever been married:

(i) If a court 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 plan years commencing after the plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Paragraph D (2)(a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court 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:

a. The plan covering the custodial parent;

b. The plan covering the spouse of the custodial parent;

c. The plan covering the non-custodial parent; and then

d. The plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one plan of individuals who are the parents of the child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in subsection D(5) within this section applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subsection D(2)(a) to the dependent child's parent(s) and the dependent's spouse.

(3) Active Employee or Retired or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is

the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.

(5) 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.

(6) 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.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When this plan is secondary, it may reduce its 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, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the Primary plan. The secondary plan may then reduce its 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, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

C. If this plan is secondary to Medicare, it may reduce its benefits so that the total benefits paid are reduced to Medicare's allowable amount, subject to our plan limits.

D. 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. Sunflower or its designated COB administrator may get the facts it needs 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. Sunflower or its designated COB administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give Sunflower or its designated COB administrator any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this plan. If it does Sunflower or its designated COB administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Sunflower or its designated COB administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made'' means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Sunflower or its designated COB administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has 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
Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any *loss* covered by the *contract*, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary should be sent to the insurer at Ambetter from Sunflower Health Plan, P.O. Box 5010, Farmington, MO 63640-5010, or to any *authorized* agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

Claim Forms
Upon receipt of a notice of claim, *we* will furnish to the *claimant* such forms as are usually furnished by *us* for filing *proofs of loss*. If such forms are not furnished within 15 days after the giving of such notice *you* shall be deemed to have complied with the requirements of this *contract* as to *proof of loss* upon submitting, within the time fixed in the *contract* 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 90 days of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than one year late will not be accepted, unless *you* or *your* covered *dependent* had no legal capacity to submit such proof during that year.

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

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

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

Timely Payment of Claims
Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to

due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims
Benefits are paid to the *member* within 30 days after receipt of a clean non-electronic claim or 15 calendar days upon receipt of a clean electronic claim.

If Sunflower Health Plan is denying or pending the claim, Sunflower Health Plan shall have 15 calendar days upon receipt of an electronic claim or 30 days upon receipt of a non-electronic claim to notify the healthcare provider or *member* of the reason for denying or pending the claim and what, if any, additional information is required to adjudicate the claim. Upon Sunflower Health Plan receipt of the requested additional information, Sunflower Health Plan shall adjudicate the claim within 45 calendar days. If the required notice is not provided, the claim shall be treated as a clean claim and shall be adjudicated.

Any claim not paid within the time periods specified shall be deemed overdue. When a claim is overdue, the healthcare provider may notify Sunflower Health Plan in writing of Sunflower Health Plan noncompliance. If *we* fail to pay the claim within the allotted time, then:

1. The amount of the overdue claim shall include an interest payment of 1.5 percent per month beginning from the date the payment was due; and
2. The healthcare provider may recover from Sunflower Health Plan, upon a judicial finding of bad faith, reasonable attorney's fees for advising and representing a healthcare provider in a successful action against *us* for payment of the claim.

Foreign Claims Incurred For *Emergency* Care
Claims incurred outside of the United States for *emergency* care and treatment of a *member* must be submitted in English or with an English translation. Foreign claims must also include the applicable medical records in English to show proper *proof of loss* and evidence of payment to 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 *contract* except for the right to receive benefits, if any, that *we* have determined to be due and payable.

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

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

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

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

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

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

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

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

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

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

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

GRIEVANCE AND COMPLAINT PROCEDURES

INTERNAL PROCEDURES

Applicability/Eligibility
The internal *appeal and grievance* procedures apply to any *hospital* or medical policy or certificate.

An eligible appellant/grievant is:
1. A *claimant;*
2. *P*erson authorized to act on behalf of the *claimant*. **Note:** Written authorization is not required; however, if received, we will accept any written expression of authorization without requiring specific form, language, or format;
3. In the event the *claimant* is unable to give consent: a *spouse*, family member, or the treating Provider; or
4. In the event of an *expedited appeal or grievance*: the person for whom the insured has verbally given authorization to represent the *claimant*.

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

Claimants have the right to submit written comments, documents, records, and other information relating to the grievance. *Claimants* have the right to present evidence and testimony as part of the internal review process.

Resolution Timeframes
Within five business days of receipt of a *grievance*, a written acknowledgment to the *claimant* or the *claimant's* authorized representative confirming receipt of the *grievance* will be delivered or deposited in the mail.

Grievances will be promptly investigated, and will be resolved within 30 calendar days of receipt. The time period may be extended for an additional 30 calendar days, making the maximum time for the entire *grievance* process 60 calendar days if *we* provide the *claimant* or the *claimant's* authorized representative, if applicable, written notification of the following within the first 30 calendar days:
    a. That *we* have not resolved the *grievance*;
    b. When *our* resolution of the *grievance* may be expected; and

c. The reason why the additional time is needed.

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

An *expedited grievance* shall be resolved as expeditiously as the *claimant's* health condition requires but not more than 72 hours after receipt of the *grievance*.

Due to the 72-hour resolution timeframe, the standard requirements for notification and acknowledgement do not apply to *expedited grievances*.

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

Written Grievance Response
Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the grievance resolution.
The written decision to the grievant must include:
1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *grievance*;

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

APPEALS
Claimants have the right to submit written comments, documents, records, and other information relating to the claim for benefits. *Claimants* have the right to review the claim file and to present evidence and testimony as part of the internal review process. A *claimant* may request an appeal within 180 days of the *adverse benefit determination.*

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

Acknowledgement
Within five business days of receipt of an *appeal*, a written acknowledgment to the *claimant* or the *claimant's* authorized representative confirming receipt of the *appeal* will be delivered or deposited in the mail.

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

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

Resolution Timeframes
All *appeals* will be resolved and we will notify the claimant in writing with the appeal decision within the following timeframes:

1. *Post-service claim*: within 60 calendar days after receipt of the *claimant*'s request for internal appeal;
2. *Pre-service claim*: within 30 calendar days after receipt of the *claimant*'s request for internal appeal.

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

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

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

An *expedited appeal* shall be resolved as expeditiously as the *claimant's* health condition requires but not more than 72 hours after receipt of the *appeal*.

Due to the 72-hour resolution timeframe, the standard requirements for notification and acknowledgement do not apply to *expedited appeals*.

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

Written Appeal Response
Appeal response letters shall describe, in detail, the *appeal* procedure and the notification shall include the specific reason for the denial, determination or initiation of disenrollment.
The written decision to the appellant must include:

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

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

Applicability/Eligibility
The External Review procedures apply to any *hospital* or medical policy or certificate.

After exhausting the internal review process, the *claimant* has 120 days to make a written request to the Kansas Insurance Commissioner for external review after the date of receipt of *our* internal response.

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

External review is available for *appeals* that involve:

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

External Review Process

1. The Kansas Insurance Commissioner has ten business days (immediately for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether:
    a. The individual was a *covered person* at the time the item or service was requested;
    b. The service is a covered service under the *claimant's* health plan but for the plan's *adverse benefit determination* with regard to medical necessity experimental/investigational, medical judgment, or *rescission*;
    c. The *claimant* has exhausted the internal process; and
    d. The *claimant* has provided all of the information required to process an external review.
2. Within ten business days (immediately for expedited) after receiving the request for external review, the Kansas Insurance Commissioner will notify the *claimant* in writing as to whether the request is complete and accepted, complete but not eligible for external review and the reasons for its ineligibility or, if the request is not complete, the additional information needed to make the request complete.

3. The Kansas Insurance Commissioner will assign an Independent Review Organization (IRO) to conduct the external review;
4. Within seven business days after the date of assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO.
   Note: For expedited, after assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method;
5. If we fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the *adverse benefit determination*;
6. The Kansas Insurance Commissioner will timely notify the *claimant* in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the *claimant* may submit in writing additional information to the IRO to consider, along with the name, address, and telephone number of the assigned IRO;
7. Upon receipt of any information submitted by the *claimant*, the IRO must forward the information to us within one business day;
8. Upon receipt of the information, we may reconsider our determination. If we reverse our *adverse benefit determination*, we must provide written notice of the decision to the *claimant,* the Kansas Insurance Commissioner, and the IRO immediately after making such decision. The external review would be considered terminated;
9. Within 30 business days (7 business days for expedited) after the date of receipt of the request for an external review, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to the *claimant,* the Kansas Insurance Commissioner, and to us. If the notice for an expedited review is not in writing, the IRO must provide written confirmation within two days after the date of providing the notice;
10. Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, we will approve the covered benefit that was the subject of the *adverse benefit determination*.

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.

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*.

Time Limit on Certain Defenses
After two years from the date of issue of this *policy* no misstatements, except fraudulent misstatement, made by the applicant in the application for such *policy* shall be used to void the *policy* or to deny a claim for loss incurred or disability commencing after the expiration of such two-year period.

No claim for loss incurred commencing after the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the *effective date* of this *policy*.

Conformity with State Laws
Any part of this *policy* in conflict with the laws of the state in which your policy was issued on this *policy's effective date* or on any premium due date is changed to conform to the minimum requirements of that state's laws.

Conditions Prior To Legal Action
No action at law or in equity shall be brought to recover on this *policy* prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this *policy*. No such action shall be brought after the expiration of five years after the time written proof of loss is required to be furnished.

Statement of Non-Discrimination

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

Ambetter from Sunflower Health Plan:

- 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 Sunflower Health Plan at 1-844-518-9505 (TTY/TDD 1-844-546-9713).

If you believe that Ambetter from Sunflower Health Plan 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 Sunflower Health Plan Appeals Unit, 8325 Lenexa Dr, Suite 200, Lenexa, KS 66214, 1-844-518-9505 (TTY/TDD 1-844-546-9713), Fax, 1-844-680-5805. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from Sunflower Health Plan is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

Ambetter from Sunflower Health Plan is underwritten by Sunflower State Health Plan, Inc.

Declaración de no discriminación

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

Ambetter de Sunflower Health Plan:

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

Si necesita estos servicios, comuníquese con Ambetter de Sunflower Health Plan a 1-844-518-9505 (TTY/TDD 1-844-546-9713).

Si considera que Ambetter de Sunflower Health Plan no le ha proporcionado estos servicios, o en cierto modo le ha discriminado debido a su raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja ante: Ambetter de Sunflower Health Plan Appeals Unit, 8325 Lenexa Dr, Suite 200, Lenexa, KS 66214, 1-844-518-9505 (TTY/TDD 1-844-546-9713), Fax, 1-844-680-5805. Usted puede presentar una queja por correo, fax, o correo electrónico. Si necesita ayuda para presentar una queja, Ambetter from Sunflower Health Plan está disponible para brindarle ayuda. También puede presentar una queja de violación a sus derechos civiles ante la Oficina de derechos civiles del Departamento de Salud y Servicios Humanos de Estados Unidos (U.S. Department of Health and Human Services), en forma electrónica a través del portal de quejas de la Oficina de derechos civiles, disponible en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* o por correo o vía telefónica llamando al: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

Ambetter de Sunflower Health Plan está asegurada por Sunflower State Health Plan, Inc.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Sunflower Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-518-9505 (TTY/TDD 1-844-546-9713).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Sunflower Health Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-518-9505 (TTY/TDD 1-844-546-9713).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Sunflower Health Plan 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-844-518-9505 (TTY/TDD 1-844-546-9713)。
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Sunflower Health Plan hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-518-9505 (TTY/TDD 1-844-546-9713) an.
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Sunflower Health Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-518-9505 (TTY/TDD 1-844-546-9713) 로 전화하십시오.
Laotian:	ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ Ambetter from Sunflower Health Plan, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ ໃຫ້ໂທຫາ 1-844-518-9505 (TTY/TDD 1-844-546-9713).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Sunflower Health Plan ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-844-518-9505 (TTY/TDD 1-844-546-9713) .
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Sunflower Health Plan, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-518-9505 (TTY/TDD 1-844-546-9713).
Burmese:	သင် သို့မဟုတ် သင်မှကူညီနေသူတစ်ဦးဦးတွင် Ambetter from Sunflower Health Plan အကြောင်း မေးစရာများရှိပါက အခမဲ့အကူအညီ ရယူပိုင်ခွင့်နှင့် သင်၏ဘာသာ စကားဖြင့် အချက်အလက်များကို အခမဲ့ရယူပိုင်ခွင့် ရှိပါသည်။ စကားပြန်တစ်ဦးနှင့် စကားပြောဆိုရန် 1-844-518-9505 (TTY/TDD 1-844-546-9713) ကို ဖုန်းဆက်ပါ။
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Sunflower Health Plan, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-844-518-9505 (TTY/TDD 1-844-546-9713).
Japanese:	Ambetter from Sunflower Health Plan について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-844-518-9505 (TTY/TDD 1-844-546-9713) までお電話ください。
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Sunflower Health Plan вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-844-518-9505 (TTY/TDD 1-844-546-9713).
Hmong:	Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Ambetter from Sunflower Health Plan, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-844-518-9505 (TTY/TDD 1-844-546-9713).
Persian:	اگر شما، یا کسی که به او کمک می کنید سؤالی در مورد Ambetter from Sunflower Health Plan دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. برای صحبت کردن با مترجم با شماره 1-844-518-9505 (TTY/TDD 1-844-546-9713)تماس بگیرید.
Swahili:	Ikiwa wewe au mtu mwingine unayemsaidia, ana maswali kuhusu Ambetter from Sunflower Health Plan, una haki ya kupata usaidizi na taarifa kwa lugha yako bila malipo. Ili kuzungumza na mkalimani, piga simu 1-844-518-9505 (TTY/TDD 1-844-546-9713).

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