Ambetter from Magnolia Health

Home Office: 111 East Capitol Street Suite 500 Jackson, MS 39201

Individual Member Contract

In this contract, "you" or "your", "yours" will refer to the member and/or any dependents. The terms "we," "our," or "us" will refer to Ambetter from Magnolia Health.

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

Annually, we must file this product, the cost share and the rates associated with it for approval. Guaranteed renewable means that your plan will be renewed into the subsequent year's approved product on the anniversary date unless terminated earlier in accordance with contract terms. You may keep this 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 will change the rate table used for this contract form. Each premium will be based on the rate table in effect on that premium’s due date. The policy plan, and age of 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.

At least 60 days' notice of any plan to take an action or make a change permitted by this clause will be delivered to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under this contract or a change in a member's health. While this contract is in force, we will not restrict coverage already in force. If we discontinue offering and decide not 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.
This contract contains prior authorization requirements. You may be required to obtain a referral from a primary care physician 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.

Ambetter from Magnolia Health

[Signature]

Aaron Sisk
CEO and Plan President
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INTRODUCTION

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

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

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

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

Ambetter from Magnolia Health operates under its legal entity, Ambetter of Magnolia.

How To Contact Us
Ambetter from Magnolia Health
111 East Capitol Street, Suite 500, Jackson, MS 39201
Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. CST, Monday through Friday

Member Services 1-877-687-1187 (Relay 711)
Fax 1- 877-941-8075
Emergency 911
24/7 Nurse Advise Line 1-877-687-1187

Interpreter Services
Ambetter from Magnolia Health has a free service to help members who speak languages other than English. These services ensure that you and your provider can talk about your medical or behavioral health concerns in a way that is most comfortable for you.

Our interpreter services are provided at no cost to you. We have representatives that speak Spanish and have medical interpreters to assist with languages other than English via telephone. Members who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation, or to request materials in Braille or large font.

To arrange for interpretation services, call Member Services at 1-877-687-1187 or for the hearing impaired (Relay 711).

Member Services Department: 1- 877-687-1187 (Relay 711)
Log on to: Ambetter.MagnoliaHealthPlan.com
MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

If you have difficulty locating a primary care provider, specialist, hospital or other contracted provider please contact us so we can assist you with access or in locating a contracted Ambetter provider. Ambetter physicians may be affiliated with different hospitals. Our online directory can provide you with information on the Ambetter contracted hospitals. The online directory also lists affiliations that your provider may have with non-contracted hospitals. Your Ambetter coverage requires you to use contracted providers with limited exceptions.

You have the right to:

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

10. Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your provider(s) of the medical consequences.

11. See your medical records.

12. Be kept informed of covered and non-covered services, program changes, how to access services, primary care provider assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and our other rules and guidelines. We will notify you at least 60 days before the effective date of the modifications. Such notices shall include the following:
   a. Any changes in clinical review criteria; or
   b. A statement of the effect of such changes on the personal liability of the member for the cost of any such changes.

13. A current list of network providers.

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

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

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

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

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

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

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

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

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

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

24. Advance directives are forms you can complete to protect your rights for medical care. It can help your primary care provider and other providers understand your wishes about your health. Advance directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself. Examples of advance directives include:
   a. Living Will
   b. Health Care Power of Attorney
   c. “Do Not Resuscitate” Orders. Members also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive.
You have the responsibility to:

1. Read this entire contract.
2. Treat all healthcare professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about your health. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your provider until you understand the care you are receiving.
4. Review and understand the information you receive about us. You need to know the proper use of covered services.
5. Show your ID card and keep scheduled appointments with your provider, and call the provider’s office during office hours whenever possible if you have a delay or cancellation.
6. Know the name of your assigned primary care provider. You should establish a relationship with your provider. You may change your primary care provider verbally or in writing by contacting our Member Services Department.
7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
8. Understand your health problems and participate, along with your healthcare professionals and providers 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 providers 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 provider.
11. Tell your healthcare professional and provider if you do not understand your treatment plan or what is expected of you. You should work with your primary care provider to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when you think you have a medical emergency. For all other care, you should call your primary care provider.
14. When you enroll in this coverage, give all information about any other medical coverage you have. If, at any time, you get other medical coverage besides this coverage, you must notify the entity with which you enrolled.
15. Pay your monthly premiums on time and pay all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service.

NOTE: Notify the Healthcare Marketplace if you have any changes to your name, address, or family members covered under this contract.
IMPORTANT INFORMATION

Provider Directory
A listing of network providers is available online at Ambetter.MagnoliaHealthPlan.com. We have plan providers, hospitals, and other medical practitioners who have agreed to provide you healthcare services. You can find 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 1-877-687-1187 (Relay 711). In order to obtain benefits, you must designate a primary care provider for each member. We can also help you pick a primary care provider (PCP). We can make your choice of primary care provider effective on the next business day.

Call the primary care provider’s office if you want to make an appointment. If you need help, call Member Services at 1-877-687-1187 (Relay 711). We will help you make the appointment.

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

The ID card will show your name, member ID# and copayment amounts required at the time of service. If you do not get your ID card within a few weeks after you enroll, please call Member Services at 1-877-687-1187 (Relay 711). We will send you another card.

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

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

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

1. Conducting a thorough check on providers when they become part of the provider network.

2. Providing programs and educational items about general healthcare and specific diseases.

3. Sending reminders to members to get annual tests such as a physical exam, cervical cancer screening, breast cancer screening, and immunizations.

4. Monitoring the quality of care and developing action plans to improve the healthcare you are receiving.

5. Investigating any member concerns regarding care received.

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

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

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

Wherever used in this contract:

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

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

**Adverse benefit determination** means a decision by us which results in:

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 experimental, 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 Grievance and Complaint Procedures section of this contract for information on your right to appeal an adverse benefit determination.

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

**Allowed amount** (also **Eligible Service Expense**) is the maximum amount we will pay a provider for a covered service. When a covered service is received from a network provider, the allowed amount is the amount the provider agreed to accept from us as payment for that particular service. In all cases, the allowed amount will be subject to cost sharing (e.g., deductible, coinsurance and copayment) per the member's benefits.
Please note, if you receive services from a non-network provider, you may be responsible for the difference between the amount the provider charges for the service (billed amount) and the allowed amount that we pay. This is known as balance billing – see balance billing and non-network provider definitions for additional information.

**Appeal** means a member or authorized representative's written request for a review of an adverse determination.

**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.

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

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

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

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

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

**Balance Billing** 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 designed to aid them in adjusting to the person's death.

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

**Care Management** is a program in which a registered nurse, or licensed mental health professional, known as a care manager, assists a member through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and health care benefits available to a member. Care management is instituted at the sole option of us when mutually agreed to by the member and the member's provider.
**Center of Excellence** means a hospital that:
1. Specializes in a specific type or types of medically necessary transplants or other services such as cancer and bariatric; and
2. Has agreed with us or an entity designated by us to meet quality of care criteria on a cost efficient basis. The fact that a hospital is a network provider does not mean it is a Center of Excellence.

**Chiropractic Care** involves neuromuscular treatment in the form of manipulation and adjustment of the tissues of the body, particularly of the spinal column and may include physical medicine modalities or use of durable medical equipment.

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

**Complaint** means any expression of dissatisfaction expressed to the insurer by the claimant, or a claimant's authorized representative, about an insurer or its providers with whom the insurer has a direct or indirect contract. **Complications of pregnancy** means:
1. Conditions whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy and not, from a medical viewpoint, associated with a normal pregnancy. This includes: ectopic pregnancy, spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, provider 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; or
2. An emergency caesarean section or a non-elective caesarean section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Effective date** means the date a member becomes covered under this contract for covered services.
**Eligible child** means the child of a covered person, if that child is less than 26 years of age. As used in this definition, "child" means:

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

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

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

1. For network providers (excluding Transplant Benefits): When a covered service is received from a network provider, the eligible service expense is the contracted fee with that provider.
2. For non-network providers:
   a. When a covered service is received from a non-network provider as a result of an emergency and there is not a sufficient number or type of network providers to render the covered service, the eligible service expense is the lesser of (1) 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), or (2) the amount accepted by the provider (not to exceed the provider's charge).
   b. When a covered service is received from a non-network provider as a result of an emergency and there is a sufficient number or type of network providers to render the covered service, the eligible service expense is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full (you will not be billed for the difference between the negotiated fee and the provider's charge). However, if the provider has not agreed to accept a negotiated fee as payment in full, the eligible service expense is the greatest of the following:
      i. the amount that would be paid under Medicare,
      ii. the amount for the covered service calculated using the same method we generally use to determine payments for out-of-network services, or
      iii. the contracted amount paid to network providers for the covered service. If there is more than one contracted amount with network providers for the covered service, the amount is the median of these amounts.
   c. When a covered service is received from a non-network provider as approved or authorized by us that is not the result of an emergency, the eligible service expense is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full (you will not be billed for the difference between the negotiated fee and the provider's charge). If there is no negotiated fee agreed to by the provider with us, the eligible service expense is the greater of (1) the amount that would be paid under Medicare, or (2) the contracted amount paid to network providers for the covered service. If there is more than one contracted amount with network providers for the covered service, the amount is the median of these amounts. Please note: You may be billed for the difference between the amount paid and the non-network provider's charge.
d. When a covered service is received from a non-network provider that is not the result of an emergency and is

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

**Emergency** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) which requires immediate (no later than 24 hours after onset) medical or surgical care and such that an average person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

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

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

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

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

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

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

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

Items (3) and (4) above do not apply to phase I, II, III or IV FDA clinical trials.

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

1. Is licensed as a hospital, extended care facility, 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 provider 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 provider; and
6. Provides each patient with active treatment of an illness or injury, in accordance with existing standards of medical practice for that condition.

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

External Independent Review means an external third-party binding review by an Independent Review Organization (IRO) after the plan’s internal grievance/appeal process has been exhausted, as applicable, and defined by the state regulations for all medical necessity denials. The request may be concurrent in the case of expedited appeals.

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 provider specialty society recommendations or professional standards of care may be considered. We reserve the right to consult medical professionals in determining whether a healthcare service, supply, or drug is medically necessary and is a covered service under the policy. The decision to apply provider specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by us.

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

1. Provision of services.
2. Determination to rescind a policy.
3. Determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders.

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

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

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

**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 provider, in accordance with existing standards of medical practice for the injury or illness requiring the home health care.

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

**Hospice** 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 a terminally ill member 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 providers available at all times;
5. Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or in facilities available to it on a prearranged basis; and
6. Is not primarily a long-term care facility; an extended care facility, nursing, rest, custodial care, or convalescent home; a halfway house, transitional facility, or residential treatment facility; a place for the aged, drug addicts, alcoholics, or runaways; a facility for wilderness or outdoor programs; or a similar establishment.

While confined in a separate identifiable hospital unit, section, or ward used primarily as a nursing, rest, custodial care or convalescent home, rehabilitation facility, extended care facility, or residential treatment...
facility, halfway house, or transitional facility, or a patient is moved from the emergency room in a short term observation status, a member will be deemed not to be confined in a hospital for purposes of this contract.

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

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

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

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

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

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

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

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

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

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

**Maximum out-of-pocket amount** is the sum of the deductible amount, prescription drug deductible amount (if applicable), copayment amount and coinsurance percentage of covered expenses, as shown in the Schedule of Benefits. After the maximum out-of-pocket amount is met for an individual, Ambetter from Magnolia Health pays 100% of eligible service expenses for that individual. The family maximum out-of-pocket amount is two times the individual maximum out-of-pocket amount. Both the individual and family maximum out-of-pocket amounts are shown in the Schedule of Benefits.

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

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

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

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

The dental maximum out-of-pocket limits do not apply to the satisfaction of the out-of-pocket maximum per calendar year as shown in the Schedule of Benefits.

**Maximum therapeutic benefit** means the point in the course of treatment where no further improvement in a 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 provider, nurse anesthetist, provider’s assistant, nurse practitioner, physical therapist, or midwife. The following are examples of providers that are NOT medical practitioners, by definition of the contract: acupuncturist, speech therapist, occupational therapist, rolf, registered nurse, hypnotist, respiratory therapist, X-ray technician, emergency medical technician, social worker, family counselor, marriage counselor, child counselor, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a member, a medical practitioner must be
licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

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

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

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

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

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

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

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

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

**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 providers who have contracts that include an agreed upon price for healthcare services or expenses.
Network eligible service expense means the eligible service expense for services or supplies that are provided by a network provider. For facility services, this is the eligible service expense that is provided at and billed by a network facility for the services of either a network or non-network provider. Network eligible service expense includes benefits for emergency health services even if provided by a non-network provider.

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

Non-Network Provider means a provider who is NOT identified in the most current list for the network shown on your identification card. Services received from a non-network provider are not covered, except as specifically stated in this contract.

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

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

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

Outpatient Surgical Facility means any facility with a medical staff of providers 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 provider offices.

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

Period of extended loss means a period of consecutive days:
1. Beginning with the first day on which a member is a hospital inpatient; and
2. Ending with the 30th consecutive day for which he or she is not a hospital inpatient.
**Physician** means a licensed medical practitioner who is practicing within the scope of his or her licensed authority in treating a bodily injury or sickness and is required to be covered by state law. A physician does NOT include someone who is related to a covered person by blood, marriage or adoption or who is normally a member of the covered person's household.

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

**Pre-service claim** means any claim for benefits for medical care or treatment that has not yet been provided and requires the approval of the plan in advance of the 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 expenses, shown in the Schedule of Benefits, if applicable, that must actually be paid during any calendar year before any prescription drug benefits are payable. The family prescription drug deductible amount is two times the individual prescription drug deductible amount. For family coverage, once a covered person has met the individual prescription drug deductible amount, any remaining family prescription drug deductible amount can be met with the combination of any one or more covered persons' eligible service expenses.

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

**Primary Care Provider (PCP)** means a provider who gives or directs health care services for you. PCP's 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 rendering service.

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

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

**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 *provider*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation licensed practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

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

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

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

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

**Respite care** means *home health care* services provided temporarily to a *member* in order to provide relief to the *member’s immediate family* or other caregiver.
Schedule of Benefits means a summary of the deductible amounts, copayment amounts, cost sharing percentages, maximums and other limits that apply when you receive covered services.

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

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

Spouse means the person to whom you are lawfully married.

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

Substance use 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 member's illness or injury by manual or instrumental operations, performed by a provider while the member is under general or local anesthesia.

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

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

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

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

1. "Well-conducted randomized controlled trials" means that two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.
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 provider’s office, that provides treatment or services that are required:

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

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

Dependent Member Eligibility

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

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

Effective Date for Initial Dependent Members

The effective date for your initial dependent members will be the same date as your initial coverage date. Only dependent members included in the application for this policy will be covered on your effective date.

Coverage for a Newborn Child

An eligible child born to you or a family member 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. The required premium will be calculated from the child’s date of birth. If notice of the newborn is given to us by the Health Insurance Marketplace within the 31 days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 days after the birth of the child. If notice is not given within the 31 days from birth, we will charge an additional premium from the date of birth. If notice is given by the Health Insurance Marketplace within 60 days of the birth of the child, the contract may not deny coverage of the child due to failure to notify us of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st day after its birth, unless we have received notice by the entity that you have enrolled (either the Marketplace or us).

Coverage for an Adopted Child

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

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

Additional premium will be required to continue coverage beyond the 31st day following placement of the child and we have received notification from the Health Insurance 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 Health Insurance Marketplace within 60 days of the birth or placement and (B) any additional premium required for the addition of the child within 90 days of the date of placement.

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

1. The date that you or your spouse assume physical custody of the child for the purpose of adoption; or
2. The date of entry of an order granting you or your spouse custody of the child for the purpose of adoption.
Adding Other Dependent Members for Non Health Insurance Marketplace Coverage
If you are enrolled in an off-exchange policy and apply in writing to add a dependent member and you pay the required premiums, we will send you written confirmation of the added dependent member’s effective date of coverage and ID cards for the added dependent member.

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

If there is no prior coverage or no continuation of inpatient coverage after the effective date, your Ambetter coverage will apply for covered benefits related to the inpatient coverage after your effective date. Ambetter coverage requires you notify Ambetter within 2 days of your effective date so we can review and authorize medically necessary services. If services are at a non-contracted hospital, claims will be paid at the Ambetter allowable and you may be billed for any balance of costs above the Ambetter allowable.
ON GOING 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 has failed to pay premiums or contributions in accordance with the terms of this contract or the date that we have not received timely premium payments in accordance with the terms of this contract;
2. The date the member has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact;
3. The date 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;
4. The date we decline to renew this contract, as stated in the Discontinuance provision;
5. The date of a covered person’s death; or
6. The date a covered person’s eligibility for insurance under this policy ceases due to losing network access as the result of a permanent move.

If you have material modifications (examples include a change in life event such as marriage, death or other change in family status), or questions related to your health insurance coverage, contact the Health Insurance Marketplace at www.healthcare.gov or 1-800-318-2596. If you enrolled through Ambetter, please contact Member Services at 1-877-687-1187.

For Dependent Members
A dependent member will cease to be a member at the end of the premium period in which he or she ceases to be your dependent member due to divorce or if a child ceases to be an eligible child. 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. At the dependent member’s request, eligibility will be continued past the age limit until the end of the month in which the dependent member reaches age 26 if the dependent member:

1. Is the natural child, stepchild or adopted child of the member.
2. Is a resident or a full-time student at an accredited higher education institution.
3. Is not employed by an employer that offers any health benefit plan under which the dependent member is eligible for coverage.
4. Is not eligible for coverage under Medicaid or Medicare.

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

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

Open Enrollment
There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 1, 2019 and extends through December 15, 2019. Qualified individuals who enroll on or prior to December 15, 2019 will have an effective date of coverage on January 1, 2020.
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 premium tax credits or cost-sharing reductions; or
2. The qualified individual pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of advanced premium tax credits and cost-sharing reduction payments until the first of the next month. We will send written annual open enrollment notification to each member no earlier than September 1

Special Enrollment
A Qualified individual has 60 days to report a qualifying event to the Health Insurance Marketplace and could be granted a 60 day Special Enrollment Period as a result of one of the following events:

1. A qualified individual or dependent loses minimum essential coverage, 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 the U.S. Department of Health and Human Services (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 advanced premium tax credits or has a chance in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan;
8. A qualified individual or enrollee gains access to new qualified health plans 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;
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.

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 premium tax credits or cost-sharing reductions; or

2. The qualified individual pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of advanced premium tax credits and cost-sharing reduction payments until the first of the next month.
PREMIUMS

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

Grace Period
When a member is receiving a premium subsidy:

After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if advanced premium tax credits are received. We will continue to pay all appropriate claims for covered services rendered to the member during the first month of the grace period, and may pend claims for covered services rendered to the member in the second and third month of the grace period. We will notify HHS of the non-payment of premiums, the member, as well as providers of the possibility of denied claims when the member is in the second and third month of the grace period. We will continue to collect advanced premium tax credits on behalf of the member from the Department of the Treasury, and will return the advanced premium tax credits on behalf of the member for the second and third month of the grace period if the member exhausts their grace period as described above. A member is not eligible to re-enroll once terminated, unless a member has a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

When a member is not receiving a premium subsidy:

Premium payments are due in advance, on a calendar month basis. Monthly payments are due 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 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.

**Misstatement of Age**
If a member’s age has been misstated, the member’s premium may be adjusted to what it should have been based on the member’s actual age.

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

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

Cost Sharing Features
We will pay benefits for covered services as described in the Schedule of Benefits and the 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 provider 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.

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

Refer to your Schedule of Benefits for Coinsurance Percentage and other limitations.
The amount provided or payable will be subject to:
1. Any specific benefit limits stated in the contract; and
2. A determination of eligible service expenses.

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

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

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

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

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

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

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

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

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

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

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

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

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

Ambetter from Magnolia Health 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 provisions of this policy. Covered service must be medically necessary and not experimental or investigational.

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

Ambulance Services
Covered service expenses will include ambulance services for local transportation:
1. To the nearest hospital that can provide services appropriate to the member’s illness or injury, in cases of emergency.
2. To the nearest neonatal special care unit for newborn infants for treatment of illnesses, injuries, congenital birth defects, or complications of premature birth that require that level of care.
3. Transportation between hospitals or between a hospital and skilled nursing or rehabilitation facility when authorized by Ambetter from Magnolia Health.

Benefits for air ambulance services are limited to:
1. Services requested by police or medical authorities at the site of an emergency.
2. Those situations in which the member is in a location that cannot be reached by ground ambulance.

Exclusions:
No benefits will be paid for:
1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-emergency air ambulance.
3. Air ambulance:
   a. Outside of the 50 United States and the District of Columbia;
   b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
   c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States.
4. Ambulance services provided for a member’s comfort or convenience.
5. Non-emergency transportation excluding ambulances.

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

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

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

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

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

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

**Outpatient**
1. Partial Hospitalization Program (PHP);
2. Intense Outpatient Program (IOP);
3. Mental Health Day treatment;
4. Outpatient detoxification programs;
5. Evaluation and assessment for mental health and substance use;
6. Individual and group therapy for mental health and substance use;
7. Medication Assisted Treatment – combines behavioral therapy and medications to treat substance use disorders;
8. Medication management services;
9. Psychological and Neuropsychological testing and assessment;
10. Applied Behavioral Analysis for treatment of autism;
11. Telemedicine;
12. Electroconvulsive Therapy (ECT);
13. Biofeedback; and
Behavioral health covered services are only for the diagnosis or treatment of mental health conditions; and the treatment of substance use/chemical dependency. Expenses for these services are covered, if medically necessary, and may be subject to prior authorization. Please see the Schedule of Benefits for more information regarding services that require prior authorization and specific benefit, day, or visit limits, if any.

**Autism Spectrum Disorder Expense Benefit**
Coverage will be provided for the screening, diagnosis and treatment of autism spectrum disorder. Treatment for autism spectrum disorder includes the following types of care prescribed, provided or ordered for an individual diagnosed with autism spectrum disorder:

1. Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible.
2. Counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor or clinical social worker; and Therapy services provided by a licensed or certified speech therapist, speech language pathologist, occupational therapist, physical therapist or marriage and family therapist.

Coverage for autism spectrum disorder includes coverage for assessments, evaluations, or tests to diagnosis an individual with autism spectrum disorder and treatment of autism spectrum disorder when medically necessary.

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

1. Covered service expenses available to a member while confined primarily to receive habilitation or rehabilitation are limited to those specified in this provision.
2. 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 service expenses for provider facility services are limited to charges made by a hospital, rehabilitation facility, or extended care facility for:
   a. Daily room and board and nursing services.
   b. Diagnostic testing.
   c. Drugs and medicines that are prescribed by a provider, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.
4. Covered service expenses for non-provider facility services are limited to charges incurred for the professional services of rehabilitation medical practitioners.
5. Outpatient physical therapy, occupational therapy and speech therapy.

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

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

1. The member has reached maximum therapeutic benefit.
2. Further treatment cannot restore bodily function beyond the level the member already possesses.
3. There is no measurable progress toward documented goals.
4. Care is primarily custodial care.

**Home Health Care Service Expense Benefits**

Member Services Department: 1-877-687-1187 (Relay 711)
Log on to: Ambetter.MagnoliaHealthPlan.com
Covered service expenses for home health care are limited to the following charges:

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

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

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

Schedule of Benefits Exclusion:
No benefits will be payable for charges related to respite care, custodial care, or educational care.

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

1. Room and board in a hospice while the member is an inpatient.
2. Occupational therapy.
4. The rental of medical equipment while the terminally ill covered person is in a hospice care program to the extent that these items would have been covered under the contract if the member had been confined in a hospital.
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
6. Counseling the member regarding his or her terminal illness.
7. Terminal illness counseling of the member’s immediate family.
8. Bereavement counseling.

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

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

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

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.

Medical and Surgical Expense Benefits
Medical covered service expenses are limited to charges:
1. For surgery in a provider’s office or at an outpatient surgical facility, including services and supplies.
2. Made by a provider for professional services, including surgery.
3. Made by an assistant surgeon.
4. For the professional services of a medical practitioner.
5. For dressings, crutches, orthopedic splints, braces, casts, or other necessary medical supplies.
6. For diagnostic testing using radiologic, ultrasonographic, or laboratory services.
7. For chemotherapy and radiation therapy or treatment.
8. For the cost and administration of an anesthetic.
9. For oxygen and its administration.
10. For dental service expenses when a member suffers an injury, after the member’s effective date of coverage, that results in:
   a. Damage to his or her natural teeth; and
   b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a provider and began within six months of the accident. Injury to the natural teeth will not include any injury as a result of chewing.
11. For reconstructive breast surgery charges as a result of a partial or total mastectomy for breast cancer. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.
12. Chiropractic services are covered when a participating chiropractor 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.
13. 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.

Member Services Department: 1- 877-687-1187 (Relay 711)
Log on to: Ambetter.MagnoliaHealthPlan.com
14. Family Planning for certain professional provider contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.

15. For medically necessary genetic blood tests.

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

17. For medically necessary biofeedback services.

18. For medically necessary allergy treatment including allergy injections.

19. For medically necessary telehealth.

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 of 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.

Second Medical Opinion

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

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

If requested, the second opinion consultation is to be provided by a provider of the member's choice. The member may select a network provider listed in the Healthcare Provider Directory. If a member chooses a network provider, 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. If a second medical opinion is obtained by a non-network provider, prior authorization must be obtained before services are considered an eligible service expense. If prior authorization is not obtained for a second medical opinion from a non-network provider, you will be responsible for the related expenses. If you see a non-network provider, you may be balance billed for services received.

Diabetic Care Expense Benefits

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

Member Services Department: 1-877-687-1187 (Relay 711)
Log on to: Ambetter.MagnoliaHealthPlan.com
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.

**Health Management Programs Offered**
Ambetter from Magnolia Health offers the following health management programs:
1. Asthma;
2. Coronary artery disease;
3. Diabetes (adult and pediatric);
4. Hypertension;
5. Hyperlipidemia;
6. Low back pain; and
7. Tobacco cessation

To inquire about these programs or other programs available, you may visit our website at Ambetter.MagnoliaHealthPlan.com or by contacting Member Services at 1-877-687-1187.

Refer to your Schedule of Benefits for any limitations associated with miscellaneous expense benefits.

**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 year per covered person.
3. For rental of medically necessary durable medical equipment.
4. For the rental of one Continuous Passive Motion (CPM) machine per covered person following a covered joint surgery.
5. For the cost of one wig per covered person necessitated by hair loss due to cancer treatments or traumatic burns.
6. For one pair of eyeglasses or contact lenses per covered person following a covered cataract surgery.

**Prescription Drug Expense Benefits**
Covered service expenses in this benefit subsection are limited to charges from a licensed pharmacy for:
1. A prescription drug.
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a provider.

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 their tier status as indicated by the formulary will be applicable.

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

The appropriate drug choice for a member is a determination that is best made by the member and his or her provider.

Notice and Proof of Loss:
90714MS001

**Member Services Department:** 1- 877-687-1187 (Relay 711)
Log on to: Ambetter.MagnoliaHealthPlan.com
In order to obtain payment for covered service 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 services provided or expenses incurred:

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

**Non-Formulary Prescription Drugs:**
Under Affordable Care Act, you have the right to request coverage of prescription drugs that are not listed on the plan formulary (otherwise known as “non-formulary drugs”). To exercise this right, please get in touch with your medical practitioner. Your medical practitioner can utilize the usual prior authorization request process. See “Prior Authorization” below for additional details.

**Prescription Drug Exception Process**

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

**Expedited exception request**
A member, a member’s designee or a member’s prescribing provider 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 provider with our coverage determination. Should the expedited exception request be granted, we will provide coverage of the non-formulary drug for the duration of the exigency.

**External exception request review**
If we deny a request for a standard exception or for an expedited exception, the member, the member’s designee or the member’s prescribing provider 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 provider of our coverage determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception.

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

**Cancer Drug Expense Benefits**
Covered service expenses in this benefit include coverage for any other use of a drug for the treatment of cancer if that drug is recognized for the treatment of that specific type of cancer, for which it has been prescribed, in one of the standard reference compendia or medical literature.

Standard reference compendia means:
1. The "United States Pharmacopoeia Drug Information"; or
2. The "American Hospital Formulary Service Drug Information".

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Log on to: Ambetter.MagnoliaHealthPlan.com
Medical literature means: two (2) articles from major peer-reviewed professional medical journals that have recognized, based on scientific or medical criteria, the drug’s safety and effectiveness for treatment of the indication for which it has been prescribed unless two (2) articles from major peer-reviewed professional medical journals have concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed. Peer-reviewed medical literature shall not include publications or supplements that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

Coverage will not include any experimental drug used for the treatment of cancer if a drug has not been approved by the FDA or the use of a drug that is contraindicated by the FDA.

**Lock-in Program**

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

**Pediatric Vision Expense Benefits – Children under the age of 19**

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

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

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.MagnoliaHealthPlan.com or call Member Services at 1-877-687-1187 (Relay 711).

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

Medically Necessary Vision Services
Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by a network provider (optometrist or ophthalmologist). Covered services include office visits, testing, and treatment of eye conditions producing symptoms that if left untreated may result in the loss of vision. Excluded services for routine and non-routine vision include:
- Visual Therapy.
- Any vision services, treatment or materials not specifically listed as a covered service.
- Low vision services and hardware for adults.
- Non network care except when pre-authorized.

Vision Expense Benefits
Non-Routine Vision, Adult and Pediatric
Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by a network provider (optometrist or ophthalmologist). Covered services include office visits, testing, and treatment of eye conditions producing symptoms that if left untreated may result in the loss of vision. Excluded services for routine and non-routine vision include:
1. Visual Therapy.
2. Any vision services, treatment or materials not specifically listed as a covered service.
3. Low vision services and hardware for adults.
4. Out of network care except when pre-authorized.

Dental Anesthesia Coverage
Covered service expenses when rendered in a hospital setting and for associated hospital charges when the mental or physical condition of the insured person requires dental treatment to be rendered in a hospital setting.

Coverage shall not apply to treatment rendered for temporomandibular joint (TMJ) disorders.

Temporomandibular Joint Disorder and Craniomandibular Disorder Expense Benefits
Covered service expenses expanded to include the charges incurred for diagnostic services and surgery for temporomandibular joint disorder and craniomandibular disorder. These expenses shall be the same as that for treatment to any other joint in the body. Coverage shall apply if the treatment is administered or prescribed by a primary care provider or dentist.
Preventive Care Expense Benefits

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

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force, including mammography.
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 for women supported by the Health Resources and Services Administration.
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.
5. Routine immunization charges for an eligible child through the age of 24 months. Coverage includes: diphtheria, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, hemophilus influenza B (HIB) and any other immunization determined to be required by law. Coverage will not be subject to a deductible, copayment or cost sharing.
6. Tobacco cessation.

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, cost sharing percentage provisions, and copayment amounts under the contract when the services are provided by a network provider. If a service is considered diagnostic or routine chronic care, your “plan” copayment, coinsurance and deductible will apply. It’s important to know what type of service you’re getting. If a diagnostic or routine chronic service is performed during the same healthcare visit as a preventive service, you may have copayment and coinsurance charges.

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

As new recommendations and guidelines are issued, those services will be considered covered service expenses when required by the HHS, but not earlier than one year after the recommendation or guideline is issued.

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 member and/or dependents receive any other covered services during a preventive care visit, the member may be responsible to pay the applicable copayment and coinsurance for those services.

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 provider or other healthcare provider obtain 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. Provider home visits and office services.
   c. Parent education, assistance, and training in breast or bottle feeding and the performance of
any necessary and appropriate clinical tests.
   d. Complications of pregnancy.
   e. Hospital stays for other medically necessary reasons associated with maternity care.

Note: This provision does not amend the contract to restrict any terms, limits, or conditions that may
otherwise apply to covered services expense for maternity care. This provision also does not require an
enrollee who is eligible for coverage under a health benefit plan to:
   (1) Give birth in a hospital or other healthcare facility; or
   (2) Remain under inpatient care in a hospital or other healthcare facility for any fixed term following
the birth of a child.

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

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

Newborns’ and Mothers’ Health Protection Act Statement of Rights
Health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of
stay in connection with childbirth for the mother or newborn child to less than 48 hours following a
vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does
not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from
discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case,
plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or
the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Transplant Expense Benefits
Covered Services For Transplant Service Expenses:
If we determine that a member is an appropriate candidate for a medically necessary transplant, covered
service expense benefits will be provided for:
   1. Pre-transplant evaluation.
   2. Pre-transplant harvesting.
   3. Pre-transplant stabilization, meaning an inpatient stay to medically stabilize a member to prepare for
a later transplant, whether or not the transplant occurs.
   4. High dose chemotherapy.
   5. Peripheral stem cell collection.
6. The transplant itself, not including the acquisition cost for the organ or bone marrow (except at a Center of Excellence).
7. Post-transplant follow-up.

Transplant Donor Expenses:
We will cover the medical expenses incurred by a live donor as if they were medical expenses of the member if:
1. They would otherwise be considered covered service expenses under the contract;
2. The member received an organ or bone marrow of the live donor; and
3. The transplant was a medically necessary transplant.

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

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these Transplant Expense Benefits:
1. For search and testing in order to locate a suitable donor.
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no medically necessary transplant occurs.
3. For animal to human transplants.
4. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
5. To keep a donor alive for the transplant operation.
6. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
7. Related to transplants not included under this provision as a medically necessary transplant.
8. For a medically necessary transplant under study in an ongoing phase I or II clinical trial as set forth in FDA regulation, regardless of whether the trial is subject to FDA oversight.

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

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

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

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

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

Benefits for repairs and replacement do not include the following:

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

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

Durable Medical Equipment

The rental (or, at our option, the purchase) of durable medical equipment prescribed by a 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:

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

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

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

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

**Prosthetics**
Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
1. Replace all or part of a missing body part and its adjoining tissues; or
2. Replace all or part of the function of a permanently useless or malfunctioning body part.

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

**Covered services** may include, but are not limited to:
1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per
Benefit Period, as required by the Women’s Health and Cancer Rights Act. Maximums for prosthetic devices, if any, do not apply.

4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.

5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are covered services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.

6. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.

7. Restoration prosthesis (composite facial prosthesis).

8. Wigs (the first one following cancer treatment, not to exceed one per benefit period).

Exclusions:
Non-covered prosthetic appliances include but are not limited to:
1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Wigs (except as described above following cancer treatment).
5. Penile prosthesis in men 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:
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.

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

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

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

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.MagnoliaHealthPlan.com or by contacting Member Services at 1-877-687-1187 (Relay 711).

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.MagnoliaHealthPlan.com or by contacting Customer Service by telephone at 1-877-687-1187 (Relay 711). 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 Required

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

For services or supplies that require prior authorization, as shown on the Schedule of Benefits, you must obtain authorization from us before you or your dependent member:
1. Receives a service or supply from a non-network provider;
2. Are admitted into a network facility by a non-network provider; or
3. Receive a service or supply from a network provider to which you or your dependent member were referred by a non-network provider.

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

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

How to Obtain Prior Authorization
To obtain prior authorization or to confirm that a network provider has obtained prior authorization, contact us by telephone at 1-877-687-1187 (Relay 711) 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. Network providers cannot bill you for services for which they fail to obtain prior authorization as required.

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

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

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

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

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

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

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

No benefits will be provided or paid for:
1. Any service or supply that would be provided without cost to the member in the absence of insurance covering the charge.
2. Expenses, fees, taxes or surcharges imposed on the member by a provider (including a hospital) but that are actually the responsibility of the provider to pay.
3. Any services performed for a member's immediate family.
4. Any services not identified and included as covered service expenses under the contract. You will be fully responsible for payment for any services that are not covered service expenses.
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 contract, no benefit will be paid for a service or supply unless it is:
1. Administered or ordered by a provider; and
2. Medically necessary to the diagnosis or treatment of an injury or illness, or covered under the Preventive Care Expense Benefits provision.

Covered service expenses will not include, and no benefits will be provided or paid for any charges that are incurred:
1. For services or supplies that are provided prior to the effective date or after the termination date of this contract, except as expressly provided for under the Benefits After Coverage Terminates clause in this contract’s Termination section.
2. For any portion of the charges that are in excess of the eligible service expense.
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
4. For cosmetic breast reduction or augmentation except the medically necessary treatment of gender dysphoria.
5. For the reversal of sterilization and vasectomies.
6. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
7. For expenses for television, telephone, or expenses for other persons.
8. For career counseling, marriage, divorce, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
9. For telephone consultations, except those meeting the definition of telehealth services, or for failure to keep a scheduled appointment.
10. For stand-by availability of a medical practitioner when no treatment is rendered.
11. For dental service expenses, including braces for any medical or dental condition, surgery and treatment for oral surgery, except as expressly provided for under Medical and Surgical Expense Benefits.
12. For cosmetic treatment, except for reconstructive surgery that is incidental to or follows surgery or an injury that was covered under the contract or is performed to correct a birth defect in a child who has been a member from its birth until the date surgery is performed.
13. For diagnosis or treatment of learning disabilities.
14. For diagnosis or treatment of nicotine addiction.
15. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
16. For eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
17. While confined primarily to receive rehabilitation, custodial care, educational care, or nursing services (unless expressly provided for in this contract).

18. For vocational or recreational therapy, vocational rehabilitation, outpatient speech therapy, or occupational therapy, except as expressly provided for in this contract.

19. 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.

20. For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this contract.

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

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

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

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

25. For or related to treatment of hyperhidrosis (excessive sweating).

26. For fetal reduction surgery.

27. Except as specifically identified as a covered service expense under the contract, services or expenses for alternative treatments, including acupressure, acupuncture, aromatherapy, hypnotherapy, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

28. As a result of any injury sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any motorized vehicle or conveyance (if the member is paid to participate or to instruct); racing or speed testing any Non-motorized vehicle or conveyance (if the member is paid to participate or to instruct); rodeo sports; horseback riding (if the member is paid to participate or to instruct); rock or mountain climbing (if the member is paid to participate or to instruct); or skiing (if the member is paid to participate or to instruct).

29. As a result of any injury sustained while operating, riding in, or descending from any type of aircraft if the member is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.

30. As a result of any injury sustained while at a residential treatment facility.

31. For prescription drugs for any member who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later date.

32. For the following miscellaneous items: biofeedback; care or complications resulting from non-covered services; chelating agents; domiciliary care; food and food supplements except for what is
indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-member biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; private duty nursing; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service area; sclerotherapy for varicose veins; treatment of spider veins; programs or services, except where required by federal or state law; transportation expenses, unless specifically described in this contract.

33. Diagnosis, treatment or surgical procedure relating to fertility or infertility.

34. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.

35. Mental Health Services are excluded: a. for evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless a Plan Provider determines such evaluation to be Medically Necessary. b. when ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless a Plan Provider determines such Services to be Medically Necessary. c. Court-ordered testing and testing for ability, aptitude, intelligence or interest.

36. Services which are custodial or residential in nature.

37. Habilitative services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.

38. 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.

39. 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;
   j. Any other health care services, supplies and medication relating to a surrogacy arrangement;
   or
   k. Any and all health care services, supplies or medication provided to any child birthed by a surrogate as a result of a surrogacy arrangement are also excluded, except where the child is the adoptive child of insureds possessing an active policy with us and/ or the child possesses an active policy with us at the time of birth.
TERMINATION

Termination of Contract
All coverage will cease on termination of this contract. This contract will terminate on the earliest of:
1. Nonpayment of premiums when due, subject to the Grace Period provision in this contract.
2. The date we receive a request from you to terminate this contract, or any later date stated in your request.
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 this contract is an Individual Plan.

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

Discontinuance
90-Day Notice: If we discontinue offering and refuse to renew all contracts issued on this form, with the same type and level of benefits, for all residents of the state of Mississippi, 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 the state of Mississippi at the time of discontinuance of this contract. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180-Day Notice: If we discontinue offering and refuse to renew all individual contracts in the individual market in the state of Mississippi, we will provide a written notice to you and the Commissioner of Insurance at least 180 days prior to the date that we stop offering and terminate all existing individual contracts in the individual market in the state of Mississippi.

Notification Requirements
It is the responsibility of you or your former dependent member to notify the Health Insurance Marketplace within 31 days of your legal divorce or your dependent member's marriage. You must notify us of the address at which their continuation of coverage should be issued.

Continuation of Coverage
We will issue the continuation of coverage:
1. No less than 30 days prior to a member's 26th birthday; or
2. Within 30 days after the date we receive timely notice of your legal divorce or dependent member's marriage. Your former dependent member must pay the required premium within 31 days following notice from us or the new contract will be void from its beginning.

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Member Services Department: 1- 877-687-1187 (Relay 711)
Log on to: Ambetter.MagnoliaHealthPlan.com
REIMBURSEMENT

If a member’s illness or injury is caused by the acts or omissions of a third party, we will not cover a loss to the extent that it is paid as part of a settlement or judgment by any third party.

However, if payment by or for the third party has not been made by the time we receive acceptable proof of loss, we will pay regular contract benefits for the member’s loss. We will have the right to be reimbursed to the extent of benefits we provided or paid for the illness or injury if the member subsequently receives any payment from any third party. The member (or the guardian, legal representatives, estate, or heirs of the member) shall promptly reimburse us from the settlement, judgment, or any payment received from any third party.

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

1. To fully cooperate with us in order to obtain information about the loss and its cause.
2. To immediately inform us in writing of any claim made or lawsuit filed on behalf of a member in connection with the loss.
3. To include the amount of benefits paid by us on behalf of a member in any claim made against any third party.
4. That we:
   a. Will have a lien on all money received by a member in connection with the loss equal to the benefit amount we have provided or paid.
   b. May give notice of that lien to any third party or third party’s agent or representative.
   c. Will have the right to intervene in any suit or legal action to protect our rights.
   d. Are subrogated to all of the rights of the member against any third party to the extent of the benefits paid on the member’s behalf.
   e. May assert that subrogation right independently of the member.
5. To take no action that prejudices our reimbursement and subrogation rights.
6. To sign, date, and deliver to us any documents we request that protect our reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a third party without providing us with written notice no less than 30 days prior to the settlement.
8. To reimburse us from any money received from any third party, to the extent of benefits we paid for the illness or injury, whether obtained by settlement, judgment, or otherwise, and whether or not the third party’s payment is expressly designated as a payment for medical expenses.
9. That we may reduce other benefits under the contract by the amounts a member has agreed to reimburse us.

Furthermore, as a condition of our payment, we may require the member or the member’s guardian (if the member is a minor or legally incompetent) to execute a written reimbursement agreement. However, the terms of this provision remain in effect regardless of whether or not an agreement is actually signed.

We have a right to be reimbursed in full regardless of whether or not the member is fully compensated by any recovery received from any third party by settlement, judgment, or limited to the extent provided by law.

We will not pay attorney fees or costs associated with the member’s claim or lawsuit unless we previously agreed in writing to do so.
If a dispute arises as to the amount a *member* must reimburse *us*, the *member* (or the guardian, legal representatives, estate, or heirs of the *member*) agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by *us* until the dispute is resolved.
CLAIMS

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

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

Cooperation Provision
Each member, or other person acting on his or her behalf, must cooperate fully with us to assist us in determining our rights and obligations under the contract and, as often as may be reasonably necessary:
1. Sign, date and deliver to us authorizations to obtain any medical or other information, records or documents we deem relevant from any person or entity.
2. Obtain and furnish to us, or our representatives, any medical or other information, records or documents we deem relevant.
3. Answer, under oath or otherwise, any questions we deem relevant, which we or our representatives may ask.
4. Furnish any other information, aid or assistance that we may require, including without limitation, assistance in communicating with any person or entity (including requesting any person or entity to promptly provide to us, or our representative, any information, records or documents requested by us).

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

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

Time for Payment of Claims
All benefits payable under this contract for an loss, other than loss for which this contract provides any periodic payment, will be paid within twenty-five (25) days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically, and will be paid within thirty-five (35) days after receipt of due written proof of such loss in the form of clean claim where claims are submitted in paper format. Benefits due under the policies and claims are overdue if not paid within twenty-five (25) days or thirty-five (35) days, whichever is applicable, after the insurer receives a clean claim containing necessary medical information and other information essential for the insurer to administer preexisting condition, coordination of benefits and subrogation provisions. A “clean claim” means a claim received by an insurer for adjudication and which requires no further information, adjustment or alteration by the provider of services or the member in order to be processed and paid by the insurer. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously
identified deficiencies corrected. Errors, such as system errors, attributable to the insurer, do not change the clean claim status.

A clean claim does not include any of the following:
1. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;
2. Claims which are submitted fraudulently or that are based upon material misrepresentations;
3. Claims that require information essential for the insurer to administer preexisting condition, coordination of benefits or subrogation provisions; or
4. Claims submitted by a provider more than thirty (30) days after the date of service; if the provider does not submit the claim on behalf of the member, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the member.

Not later than twenty-five (25) days after the date the insurer actually receives an electronic claim, the insurer shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the member (where the claim is owed to the member) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date the insurer actually receives a paper claim, the insurer shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the member (where the claim is owed to the member) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by the insurer shall be paid within twenty (20) days after receipt.

For purposes of this provision, the term “pay” means that the insurer shall either send cash or a cash equivalent by United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due the provider (where the claim is owed to the provider) or the member (where the claim is owed to the member). To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the provider (where the claim is owed to the provider) or the member (where the claim is owed to the member) in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to the provider or member.

If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, the insurer must pay the provider (where the claim is owed to the provider) or the member (where the claim is owed to the member) interest on accrued benefits at the rate of three percent (3%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest is due pursuant to this provision is less than One Dollar ($1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed. The provisions of this paragraph shall not apply to any claims or benefits owed under Medicare Advantage plans or Medicare Advantage Prescription Drug plans.

In the event the insurer fails to pay benefits when due, the person entitled to such benefits may bring action to recover such benefits, any interest which may accrue as provided in the above paragraph of this section and any other damages as may be allowable by law. If it is determined in such action that the insurer acted in bad faith as evidenced by a repeated or deliberate pattern or failing to pay benefits and/or
claims when due, the person entitled to such benefits (health care provider or member) shall be entitled to recover damages in an amount up to three (3) times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

**Payment of Claims**

Except as set forth in this provision, all benefits are payable to you. Any accrued benefits unpaid at your death, or your dependent member’s death may, at our option, be paid either to the beneficiary or to the estate. If any benefit is payable to your or your dependent member’s estate, or to a beneficiary who is a minor or is otherwise not competent to give valid release, we may pay up to $1,000 to any relative who, in our opinion, is entitled to it.

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

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

When a covered service is received from a non-network provider as a result of an emergency, members may be responsible for amounts above the eligible service expense.

If the member provides the insurer with written direction that all or a portion of any indemnities or benefits provided by the contract be paid to a licensed health care provider rendering hospital, nursing, medical or surgical services, then the insurer shall pay directly the licensed health care provider rendering such services. That payment shall be considered payment in full to the provider, who may not bill or collect from the member any amount above that payment, other than the deductible, coinsurance, copayment or other charges for equipment or services requested by the insured that are noncovered benefits.

**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 include the applicable medical records in English to show proper proof of loss and evidence of payment to the provider.

**Assignment**

The coverage, rights, privileges and benefits provided for under this contract are not assignable by you or anyone acting on your behalf, except that you may assign your benefits under this policy to a licensed healthcare provider that provides healthcare services to you. We shall honor any such assignments by you to a licensed healthcare provider that provides healthcare services to you for a period of one (1) year starting from the initial date of an assignment. Otherwise, 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.

**Medicaid Reimbursement**

90714MS001  

Member Services Department: 1- 877-687-1187 (Relay 711)  
Log on to: Ambetter.MagnoliaHealthPlan.com
The amount provided or payable under this *contract* will not be changed or limited for reason of a *member* being eligible for coverage under the Medicaid program of the state in which he or she lives.

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

1. A *member* is eligible for coverage under his or her state’s Medicaid program; and
2. *We* receive proper *proof of loss* and notice that payment has been made for *covered service expenses* under that program.

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

**Custodial Parent**

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

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

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

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

**Physical Examination**

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

**Legal Actions**

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

The coordination of benefits (COB) provision applies when you have health care coverage under more than one plan is defined below.

The order of benefit determination rules govern the order which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits according to its 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 do not exceed 100 percent of the total allowable expense.

Definitions

For the purpose of this section, the following definitions shall apply:

A Plan is any of the following that provides benefits or services for medical 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.

1. Plan includes: group and non-group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; uninsured arrangements of group or group-type coverage; coverage under group or non-group closed panel plans; group-type contracts; medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether “fault” or “no fault”); other governmental benefits, except for Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

2. Plan does not include: limited occurrence policies which provide only for intensive care or coronary care at a hospital, first-aid outpatient medical expenses resulting from accidents, or specified accidents such as travel accidents; accident only coverage; specified disease or specified accident coverage; limited health benefit coverage; benefits for non-medical components of long-term care policies; hospital indemnity coverage benefits or other fixed indemnity coverage; school accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under the above is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan. This plan means, in 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.

The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when you have 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 must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total allowable expense for
that claim. This means that when this plan is secondary, it must pay the amount that which, when combined with what the primary plan paid, totals not less than the same allowable expense that this plan would have paid if it were the primary plan.

**Allowable Expense** is a health care expense, including *deductibles, coinsurance* and *copayments*, that is covered at least in part by any plan covering *you*. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering *you* is not an allowable expense. The following are examples of expenses that are not allowable expenses:

1. The difference between the cost of a semi-private *hospital* room and a private *hospital* room is not an allowable expense, unless one of the plans provides coverage for private *hospital* room expenses.
2. If *you* are covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
3. If *you* are covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

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

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

**Order of Benefit Determination Rules**

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

**Non-Dependent or Dependent.**

The plan that covers *you* other than as a dependent, (for example as an employee, *member*, policyholder, subscriber or retiree) is the primary plan and the plan that covers *you* as a dependent is the secondary plan. However, if *you* are a Medicare beneficiary or Medicaid beneficiary and, as a result of federal law, Medicare or Medicaid is secondary to the plan covering *you* as a dependent, and primary to the plan covering *you* as other than a dependent, then the order of benefits between the two plans is reversed so
that the plan covering you as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.

**Child Covered Under More Than One Plan.**

Unless there is a court decree stating otherwise, when a child is covered by more than one plan the order of benefits is determined as follows:

1. For a child whose parents are married or are living together, whether or not they have ever been married:
   a. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
   b. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

2. For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   a. If a court decree states that one of the parents is responsible for the child’s 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, then that parent’s spouse’s plan is the primary plan. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;
   b. If a court decree states that both parents are responsible for the child’s health care expenses or health care coverage, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits;
   c. 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 child, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits; or
   d. If there is no court decree allocating responsibility for the child’s health care expenses or health care coverage, the order of benefits for the child are as follows:
      i. The plan covering the custodial parent, first;
      ii. The plan covering the spouse of the custodial parent, second;
      iii. The plan covering the noncustodial parent, third; and then
      iv. The plan covering the spouse of the noncustodial parent, last.

3. For a child covered under more than one plan of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for child(ren) whose parents are married or are living together or for child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

**Active Employee or Retired or Laid-off Employee**

The plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering you as a retired or laid-off employee is the secondary plan. The same would hold true if you are a dependent of an active employee and you are a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the non-dependent or dependent provision above can determine the order of benefits.
COBRA or State Continuation Coverage
If your coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering you as an employee, member, subscriber or retiree or covering you as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the non-dependent or dependent provision above can determine the order of benefits.

Longer or Shorter Length of Coverage
The plan that covered you the longer period of time is the primary plan and the plan that covered you the shorter period of time is the secondary plan. If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of This Plan
When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim are not less than the same allowable expense as the secondary plan would have paid if it was the primary plan. Total allowable expense is the highest allowable expense under this Plan. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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

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

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

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

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

CAUTION: All health plans have timely claim filing requirements. If you or your provider fail(s) to submit your claim to a secondary health plan within that plan’s claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim. To avoid delays in claim processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage.
GRIEVANCE AND COMPLAINT PROCEDURES

INTERNAL PROCEDURES:

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

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

Important: Adverse benefit determinations that are not grievances will follow standard Affordable Care Act internal appeals processes.

Your rights to file an internal grievance appeal of a denial of health benefits: You or your authorized representative may file the grievance appeal for you, in writing, either by mail or by facsimile (fax). For an urgent request, you may also file a grievance by telephone to:

Ambetter from Magnolia Health
Attn.: Appeals Unit/Appeals Coordinator
111 East Capitol Street Suite 500
Jackson, MS 39201
Phone: 1-877-687-1187
Fax: 1-877-264-6519

Grievances
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. You have up to 180 calendar days to file a grievance. The 180 calendar days start on the date of the situation you are not satisfied with.

Grievances 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.

Resolution Timeframes
1. Grievances regarding quality of care, quality of service, or reformation will be resolved within 30 calendar days of receipt. The time period may be extended for an additional 14 calendar days (making the maximum time for the entire grievance process 45 calendar days) if we provide the claimant and the claimant’s authorized representative, if applicable, written notification of the following within the first 30 calendar days:

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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.

2. All other grievances will be resolved and we will notify the claimant in writing with the appeal decision within the following timeframes:
   a. Post-service claim: within 60 calendar days after receipt of the claimant’s request for internal appeal.
   b. 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. 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. 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.

Refer to a later section for information regarding internal expedited grievances.

Acknowledgement
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 must be delivered or deposited in the mail.

When acknowledging a grievance filed by an authorized representative, the acknowledgement shall include a clear and prominent notice that healthcare 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, healthcare information or medical records may be withheld from an authorized representative, including information contained in its resolution of the grievance.
3. A grievance submitted by an authorized representative will be processed regardless of whether healthcare information or medical records may be disclosed to the authorized representative under applicable law.

Expedited Grievance

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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, grievance panel/right to appear, 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 specific reason for the denial, determination or initiation of disenrollment.

The panel’s 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;
3. 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 healthcare provider’s name;
   i. The claim amount;
   j. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
   k. The health plan’s denial code with corresponding meaning;
   l. A description of any standard used, if any, in denying the claim;
   m. A description of the external review procedures, if applicable;
   n. The right to bring a civil action under state or federal law;

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Complaints

Basic elements of a complaint include:

1. The complainant is the claimant or an authorized representative of the claimant;
2. The submission may or may not be in writing; and
3. The issue may refer to any dissatisfaction about:
   a. Us (as the insurer); e.g., Member Services complaints - “the person to whom I spoke on the phone was rude to me”;
   b. Providers with whom we have a direct or indirect contract:
      i. Lack of availability and/or accessibility of network providers not tied to an unresolved benefit denial;
         Note: When the dissatisfaction is related to services from or access to a network provider, notify the Provider Relations and Network Development Departments.
      ii. Quality of care/quality of service issues;
4. Written expressions of dissatisfaction regarding quality of care/quality of service are processed as grievances.
5. Oral expressions of dissatisfaction regarding quality of care/quality of service are processed as complaints as indicated in standard oral complaint instructions.
6. Any of the issues listed as part of the definition of grievance received from the claimant or the claimant’s authorized representative where the caller has not submitted a written request but calls us to escalate their dissatisfaction and request a verbal/oral review.

Complaints received from the State Insurance Department

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

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 review organization.

Applicability/Eligibility

The Grievance procedures apply to:

1. Any hospital or medical policy or certificate; excluding accident only or disability income only insurance.

After exhausting the internal review process, the claimant has four months to make a written request to the State Insurance Department 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 with the plan at the time the claimant receives:
   a. An adverse benefit determination if the determination involves a medical condition of the claimant for which the timeframe for completion of an internal expedited 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;
   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 healthcare item or service for which the claimant received emergency services, but has not been discharged from a facility.

3. Claimants may request an expedited external review at the same time the internal expedited grievance is requested and the State Insurance Department will determine if the internal expedited grievance needs to be completed before proceeding with the expedited external review.

External review is available for grievances that involve:
1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, healthcare 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. We have five business days (immediately for expedited) following receipt from the State Insurance Department 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 one business day (immediately for expedited) after completion of the preliminary review, we will notify the claimant in writing as to whether the request is complete but not eligible for external review and the reasons for its ineligibility or, if the request is not complete, the additional information needed to make the request complete.

3. We must allow a claimant to perfect the request for external review within the four-month filing period.

4. Within one business day after receiving notice that a request is eligible for external review following the preliminary review, the State Insurance Department will assign an independent review organization (IRO) to conduct the external review and will notify us of the name of the assigned IRO. The State Insurance Department will notify in writing the claimant of the request’s eligibility and acceptance for review. Included in the notification to the claimant shall be a statement that the claimant may submit in writing to the assigned IRO within five business days following the date of receipt of the notice additional information that the IRO shall consider when conducting the external review.
review. The IRO is not required to, but may, accept and consider additional information submitted after five business days.

5. Within five business days after the date of assignment of the IRO, we must provide the documents and any information considered in making the adverse benefit determination to the IRO.

Note: For expedited, after assignment of the IRO, we must provide the documents and any information considered in making the adverse benefit determination to the IRO electronically or by telephone or facsimile or any other available expeditious method.

6. If we fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination.

7. 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 State Insurance Department and the assigned IRO within one business day after making such decision. The external review would be considered terminated.

9. Within 45 days (72 hours for expedited) after the date of receipt of the request for an external review from the health plan, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the adverse benefit determination to the claimant and to us. If the notice for an expedited review is not in writing, the IRO must provide written confirmation within 48 hours 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 contract, with the application is the entire contract between you and us. No agent may:
1. Change this contract;
2. Waive any of the provisions of this contract;
3. Extend the time for payment of premiums; or
4. Waive any of our rights or requirements.

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

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

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

Conformity with State Laws
Any part of this contract in conflict with the laws of Mississippi on this contract's effective date or on any premium due date is changed to conform to the minimum requirements of Mississippi state laws.
Statement of Non-Discrimination

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

Ambetter from Magnolia Health:

- 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 Magnolia Health at 1-877-687-1187 (Relay 711).

If you believe that Ambetter from Magnolia Health 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: Grievance Coordinator, 111 E Capitol Street, Suite 500, Jackson, MS 39201, 1-877-687-1187 (Relay 711), Fax 1-877-264-6519. You can file a grievance by phone, mail, or fax. If you need help filing a grievance, Ambetter from Magnolia Health 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).

Declaración de no discriminación

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

Ambetter de Magnolia Health:

- 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 Magnolia Health a 1-877-687-1187 (Relay 711).

Si considera que Ambetter de Magnolia Health 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: Grievance Coordinator, 111 E Capitol Street, Suite 500, Jackson, MS 39201, 1-877-687-1187 (Relay 711), Fax 1-877-264-6519. Usted puede presentar una queja por teléfono, correo, fax. Si necesita ayuda para presentar una queja, Ambetter de Magnolia Health 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).


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