ambetter.
of Tennessee

2021 Evidence of Coverage

AmbetterofTennessee.com

70111TN011

Ambetter of Tennessee

Issued and Underwritten by Celtic Insurance Company

Home Office: 200 East Randolph Street, Suite 5020, Chicago, IL 60601

Individual Member Contract

In this *contract,* the terms *"you"*, *"your"*, or *"yours"* will refer to the *member* or any *dependents* enrolled in this *contract*. The terms *"we,"* *"our,"* or *"us"* will refer to Ambetter of Tennessee.

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 is found to be in material breach of this Contract; or (3) 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.

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

TEN DAY RIGHT TO RETURN POLICY

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

Ambetter of Tennessee

Kevin J. Counihan, President

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INTRODUCTION

Welcome to Ambetter of Tennessee. We have prepared this *contract* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services.
It describes:

- How to access medical care.
- The health care services we cover.
- The portion of your health care 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 and 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 in the Definitions section. This Contract also contains exclusions, so please be sure to read this entire Contract carefully.

How to Contact Us
Ambetter of Tennessee
12515-8 Research Blvd. Suite 400
Austin, TX 78759

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST

Member Services	**1-833-709-4735**
TDD/TTY line	**Relay 711**
Fax	**1-833-283-4807**
Emergency	**911**

24/7 Nurse Advice Line **1-833-709-4735** or for hearing impaired TDD/TTY **Relay 711**

Interpreter Services
Ambetter of Tennessee 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 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, please call Member Services at 1-833-709-4735 or for the hearing impaired (Relay 711).

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 health care 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* health care. 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:

   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*, at no cost to *you*, if *you* 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; or
   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 health care 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* health care professionals and *providers* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* or *your* health care 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* health care professionals and *provider*.
11. Tell *your* health care 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 tell 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.
16. Inform the entity in which *you* enrolled for this *contract* if *you* have any changes to *your* name, address, or family members covered under this *contract* within 60 days from the date of the event.

IMPORTANT INFORMATION

Provider Directory
A listing of *network providers* is available online at www.ambetteroftennessee.com. *We* have plan *providers*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* with *your* healthcare services. *You* may find any of *our network providers* by completing the "Find a Provider" function on *our* website and selecting the Ambetter Network. There *you* will have the ability to narrow *your* search by *provider* specialty, zip code, gender, languages spoken and whether or not they are currently accepting new patients. *Your* search will produce a list of *providers* based on *your* search criteria and will give *you* other information such as name, address, phone number, office hours, and specialty and board certifications.. At any time, *you* can request a copy of the provider directory at no charge by calling Member Services at 1-833-709-4735 (Relay 711). In order to obtain benefits, *you* must designate a *primary care provider* for each *member. We* can help *you* pick a *primary care provider* (*PCP*). *We* can make *your* choice of *primary care provider* effective on the next business day.

Call the *primary care provider*'s office if *you* want to make an appointment. If *you* need help, call Member Services at 1-833-709-4735 (Relay 711). *We* will help *you* make the appointment.

Member ID Card
When *you* enroll, *we* will mail *you* a Member ID card after *our* receipt of *your* completed enrollment materials and you had paid *your* initial premium payment. This card is proof that *you* are enrolled in the 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 1-833-709-4735 (Relay 711). *We* will send *you* another card.

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

1. Finding a *network provider*.
2. Locate other *providers* (e.g., hospitals and pharmacies)
3. *Our* programs and services, including programs to help *you* get and stay healthy.
4. A secure portal for *you* to check the status of *your* claims, make payments, and obtain a copy of *your* Member ID card.
5. Member Rights and Responsibilities.
6. Notice of Privacy Practices.
7. Current events and news.
8. *Our* Formulary or Preferred Drug List.
9. *Deductible* and *copayment* accumulators.
10. Selecting a *Primary Care Provider*.

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.

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

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

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

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

DEFINITIONS

In this *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 Health Insurance Marketplace. *Advanced premium tax credits* can be used right away to lower *your* monthly premium costs. If *you* qualify, *you* may choose how much *advanced premium tax credit* to apply to *your* premiums each month, up to the maximum amount. If the amount of *advanced premium tax credits you* receive for the year is less than the total tax credit *you're* due, *you'll* get the difference as a refundable credit when *you* file *your* federal income tax return. If *your advanced premium tax credits* for the year are more than the total amount of *your* premium tax credit, *you* must repay the excess *advanced premium tax credit* with *your* tax return.

Adverse Benefit Determination is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension or termination of a previously *authorized* service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure to act within the time frames specified for making or notifying the *member* of such action.

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. A *non-network provider* must give you a detailed breakdown of the estimated amount you will pay out of pocket for the non-*network* services, for you or your personal representative to sign (Tenn. Code Ann. 68-11-243). Be sure to always check whether a provider you are referred to is in our *network*.

Please note, if you receive services that have not been approved by Ambetter of Tennessee from a *non-network provider* when a *network provider* is available, 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 request for Ambetter to reconsider a previous decision including an adverse determination or final adverse determination.

Applied behavior analysis or ***ABA*** is the application of behavioral principles to everyday situations, intended to increase or decrease targeted behaviors. *ABA* has been used to improve areas such as language, self-help, and play skills, as well as decrease behaviors such as aggression, self-stimulatory behaviors, and self-injury.

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

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.

Authorized Representative means an individual who represents a *covered* person in a *grievance*, *complaint* or 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;
- A family member or a treating health care professional, but only when the *covered person* is unable to provide consent;
- A health care professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or
- In the case of an urgent care request, a health care professional with knowledge of the *covered person*'s medical condition.

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. See the Allowed Amount definition for more detail.*

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

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

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

Care Management is a program in which a registered nurse or licensed mental health professional, known as a care manager, assists a *member* through a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and health care benefits available to a *member*. *Care management* is instituted when mutually agreed to by *us*, 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 or infertility; and
2. Has agreed with *us* or an entity designated by *us* to meet quality of care criteria on a cost efficient basis. The fact that a *hospital* is a *network provider* does not mean it is a *Center of Excellence.*

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*.

Claimant means a member, a member's ***Authorized Representative***, or provider acting on the member's behalf who files a *grievance* or appeal.

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*.
2. An *emergency* caesarean section or a *non-elective caesarean section*.

Contract (or "policy") refers to this *contract* 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 Health Insurance Marketplace or be a member of a federally recognized American Indian tribe and/or an Alaskan Native enrolled in a QHP through the Health Insurance Marketplace.

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

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

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

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

Custodial care includes (but is not limited to) the following:

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

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

Deductible amount or ***Deductible*** means the amount that *you* must pay in a *calendar year* for *covered service 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;
4. A child for whom legal guardianship has been awarded to *you* or *your spouse*; or
5. A stepchild.

It is *your* responsibility to notify the entity with which you enrolled (either the Health Insurance 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*: 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*, 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 with *us* 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.

    Please note: *You* may be billed for the difference between the amount paid and the *non-network provider's* charge.

    b. When a *covered service* is received from a *non-network provider* as *approved* or *authorized* by *us* and 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. *You* will not be billed for the difference between the amount paid and the *provider's* charge.

    c. When a *covered service* is received from a *non-network provider* because the service or supply is not available from any *network provider* in *your service area* and is not the result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that the *provider* has agreed to accept 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* will not be billed for the difference between the amount paid and the *provider's* charge.

Emergency (Medical, Behavioral Health, and Substance Use) Services means covered inpatient and *outpatient services* that are (1) furnished by a provider qualified to furnish these services and (2) needed to evaluate or stabilize an emergency medical/behavioral health condition. An emergency medical/behavioral health condition means a medical, mental health, or substance use-related condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the *member* (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious harm to self or others due to an alcohol or drug use emergency; Injury to self or bodily harm to others; or with respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to another *hospital* before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Follow-up care is not considered emergency care. Benefits are provided for treatment of *emergency* medical conditions and *emergency* screening and stabilization services without *prior authorization*. Benefits for *emergency* care include facility costs and *provider* services, and supplies and *prescription drugs* charged by that facility. *You* must notify *us* or verify that *your provider* has notified *us* of *your* admission to a *hospital* within 48 hours or as soon as possible within a reasonable period of time. When *we* are contacted, *you* will be notified whether the *inpatient* setting is appropriate, and if appropriate, the number of days considered *medically necessary*. By contacting *us*, *you* may avoid financial responsibility for any *inpatient* care that is determined to be not *medically necessary* under *your* Plan. If *your provider* does not contract with *us*, *you* will be financially responsible for any care *we* determine is not *medically necessary*. Care and treatment provided once *you* are *medically stabilized* is no longer considered *emergency* care. Continuation of care from a non-participating *provider* beyond that needed to evaluate or stabilize *your* condition in an *emergency* will be covered as a non-*network* service unless *we authorize* the continuation of care and it is *medically necessary*.

Enhanced Direct Enrollment (EDE) is an Ambetter tool that allows you to apply for coverage, renew, and report life changes entirely on our website without being redirected to the Health Insurance Marketplace (Healthcare.gov). If you have utilized enroll.ambetterhealth.com to apply or renew, a consumer dashboard has been created for you. You can log in to your consumer dashboard at enroll.ambetterhealth.com.

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 or annual dollar maximum.

Expedited appeal means an *appeal* 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 *appeal*.

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

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("*FDA*") regulation, regardless of whether the trial is subject to *USFDA* 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 III or IV *FDA* clinical trials. Benefits are available for routine care costs that are incurred in the course of a clinical trial if the services provided are otherwise *covered services* under this *contract*.

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 *generally accepted standards of medical practice* for that condition.

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

External appeal is a request for an independent, external review of the *final adverse determination* made by the Plan through its internal appeal process. This may include, but is not limited to, Independent Review Entity or Quality Improvement Organization.

Final adverse determination means an adverse determination involving a covered benefit that has been upheld by a health carrier at the completion of the health carrier's internal *grievance* process procedures.

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 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 health care service, supply, or drug is *medically necessary* and is a *covered service* under the *contract*. 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 a written or oral complaint about the quality of service or medical care by, or on behalf of a *covered person,* by a provider or an *authorized representative* regarding:

1. Availability, delivery or quality of healthcare services regarding an adverse determination;
2. Claims payment, handling or reimbursement for healthcare services;
3. Matters pertaining to the contractual relationship between a *covered person* and an insurer; or
4. Matters pertaining to the contractual relationship between a healthcare provider and an insurer.

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.

Health Management means a program designed specially to assist you in managing a specific or chronic health condition.

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 *generally accepted 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 health 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 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*.

Independent Review Organization (IRO) means an entity that conducts independent external reviews of adverse determinations and final adverse determinations of a health carrier (also known as an External Review Organization (ERO).

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, or *substance use* are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

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

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

For family coverage, the family *maximum out-of-pocket amount* can be met with the combination of any *covered persons' eligible service 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 out-of-pocket maximum limits do not apply to the satisfaction of the *maximum out-of-pocket* per *calendar year* as shown in the *Schedule of Benefits*.

Maximum therapeutic benefit means the point in the course of treatment where no further improvement in a *covered person's* medical condition can be expected, even though there may be fluctuations in levels of pain and function.

Medical practitioner includes but is not limited to a *provider*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of *providers* that are NOT *medical practitioners*, by definition of the *contract:* acupuncturist, speech therapist, occupational therapist, rolfer, 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 standards of medical practice*;
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 no further material deterioration of a person's condition, within a reasonable probability, would result during transfer from a medical facility, as a result of a prior *injury* or *illness or* acute medical care. Acute medical care does not include *acute rehabilitation*.

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

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

Mental health 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 *medical practitioners* and *providers* who have contracts that include an agreed upon price for health care 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-elective caesarean section means:

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

Non-network provider means a *medical practitioner* who is NOT 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 a *medically necessary* device used to support, align, prevent or correct deformities, protect a body function, improve the function and moveable body part or assist with dysfunctional joints. Orthotics must be used to for therapeutic support, protection, restoration or function of an impaired body part for treatment of an *illness* or *injury*.

Other plan means any plan or contract 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 *covered person* who has chronic pain that significantly interferes with physical, psychosocial, and vocational functioning, for the purpose of reducing pain, improving function, and decreasing dependence on the health care system. A *pain management program* must be individualized and provide physical *rehabilitation*, education on pain, relaxation training, and medical evaluation.

Physician or ***Provider*** 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* or *provider* 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.

Pre-service appeal is a request to change an adverse determination for care or service that the Plan must approve, in whole or in part, in advance of the *member* obtaining care or services.

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

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

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

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

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

Qualified health plan or ***QHP*** means a health plan that has in effect a certification that it meets the standards described in 45 CFR Subpart C, Part 156 issued or recognized by each Health Insurance Marketplace through which such plan is offered in accordance with the process described in 45 CFR Subpart K, 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 cardiac rehabilitation. 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.

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 contract means a determination by an insurer to withdraw the coverage back to the date of the act that prompts the *rescission*.

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*, *copayment*, *coinsurance*, *maximum out-of-pocket*, and other limits that apply when *you* receive *covered services* and supplies.

Service Area means a geographical area, made up of counties, where *we* have been authorized by the State of Tennessee to sell and market *our* health plans. This is where the majority of *our* participating *providers*

are located where *you* will receive all of *your* health care services and supplies. *You* can receive precise *service area* boundaries from *our* website or *our* Member Services department.

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

Specialist 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.

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.

Surrogacy/Gestational Carrier Arrangement means an understanding in which a woman (the surrogate/gestational carrier) 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/gestational carrier receives payment for acting as a surrogate/gestational carrier.

Surrogate/Gestational Carrier means an individual who, as part of a *Surrogacy Arrangement,* (a) uses her own egg that is fertilized by a donor or (b) is a gestational carrier who 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 *contract* 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 or nicotine use or ***use of tobacco or nicotine*** means *use of tobacco or nicotine* by individuals who may legally use nicotine or 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 and nicotine products, e-cigarettes or vaping devices, 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, which are determined not to be effective for treatment of the medical condition, or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from *well-conducted randomized controlled trials* or *well-conducted cohort studies* in the prevailing published peer-reviewed medical literature.

1. *"Well-conducted randomized controlled trials"* means that two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.
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 insurance on the latter of:

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

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

Coverage for a Newborn Child
An *eligible child* born to *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 Health Insurance Marketplace of the child's birth.

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
If *you* are enrolled in an off-exchange *contract* 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*.

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

If there is no prior coverage or no continuation of *inpatient* coverage after the *effective date*, your Ambetter coverage will apply for covered benefits related to the *inpatient* coverage after your *effective date*. Ambetter coverage requires you notify Ambetter within 2 days of your *effective date* so we can review and *authorize medically necessary* services. If services are at a non-contracted *hospital*, claims will be paid at the Ambetter allowable and you may be billed for any balance of costs above the Ambetter allowable.

ONGOING ELIGIBILITY

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

1. The primary *member* residing outside the *service area* or moving permanently outside the *service area* of this plan;
2. The date of termination that the Health Insurance Marketplace provides us upon your request of cancellation to the Health Insurance 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;
3. 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;
4. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or
5. The date of a *member's* death.
6. The date we decline to renew this contract, as stated in the Discontinuance provision.

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*, the coverage will terminate at 11:59 p.m. on the last day of the year in which dependent child reaches the limiting age of 26. All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*.

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

1. Incapable of self-sustaining employment by reason of intellectual or physical disability ; and
2. Chiefly dependent upon you for support and maintenance, provided proof of the incapacity and dependency is furnished to us within thirty-one (31) days of the dependent eligible child attainment of the limiting age and subsequently as may be required by us, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Open Enrollment
There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 1, 2020 and extends through December 15, 2020. *Qualified individuals* who enroll on or before December 15, 2020 will have an *effective date* of coverage on January 1, 2021.

Special and Limited Enrollment
A *qualified individual* has 60 days to report a qualifying event to the Health Insurance Marketplace or by using Ambetter's *Enhanced Direct Enrollment* tool, 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, placement for adoption, placement in foster care, or a child support order or other court order of a *member* or their *spouse*;
    a. In the case of marriage, at least one *spouse* must demonstrate having minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage.

3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
4. An individual who is no longer incarcerated or whose incarceration is pending the disposition of charges;
5. A *qualified individual's* enrollment or non-enrollment in a *qualified health plan* is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace or HHS, or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
6. An enrollee adequately demonstrates to the Health Insurance Marketplace that the *qualified health plan* in which he or she is enrolled substantially violated a material provision of its *contract* in relation to the enrollee's decision to purchase the *qualified health plan* based on plan benefits, *service area* or premium;
7. An individual is determined newly eligible or newly ineligible for *advance 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; or
11. A *qualified individual* or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide;
12. A *qualified individual* or *dependent* is a victim of domestic abuse or spousal abandonment and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
13. A *qualified individual* or *dependent* is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 days after the qualifying event or;
14. At the option of the Health Insurance Marketplace, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a *qualified health plan* through the Health Insurance Marketplace following termination of Health Insurance 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.
15. A qualified individual newly gains access to an employer sponsored individual coverage HRA or a Qualified Small Employer Health Reimbursement Arrangement (HRA).

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.

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.

PREMIUMS

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

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

> After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if *advance premium tax credits* are received.
>
> *We* will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period, and 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 *advance premium tax credits* on behalf of the *member* from the Department of the Treasury, and will return the *advance premium tax credits* on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above. 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 sixty-day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *contract* will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. *We* will notify HHS, as necessary, of the non-payment of premiums, the *member*, as well as *providers* of the possibility of denied claims when the *member* is in the grace period.

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

1. Ryan White HIV/AIDS program under Title XXVI of the Public Health Service Act;
2. Indian tribes, tribal organizations, or urban Indian organizations;
3. State and Federal government programs; or
4. Family members.
5. Private, not-for-profit foundations which have no incentive for financial gain, no financial relationship, or affiliation with *providers* of *covered services* and supplies on behalf of *members,* where eligibility is determined based on defined criteria without regard to health status and where payments are made in advance for a coverage period from the *effective date* of eligibility through the remainder of the calendar year.

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

Similarly, if we determine payment was made for *deductibles* or *cost sharing* by a *third party*, such as a drug manufacturer paying for all or part of a medication, that shall be considered a *third party* premium payment that may not be counted towards your *deductible* or *maximum out-of-pocket* costs.

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

Change or Misstatement of Residence
If *you* change *your residence*, *you* must notify the 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* will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

PRIOR AUTHORIZATION

Ambetter reviews services to ensure the care you receive is the best way to help improve your health condition. Utilization review includes:
• Pre-service or prior authorization review – occurs when a medical service has been pre-approved by Ambetter
• Concurrent review – occurs when a medical service is reviewed as they happen (e.g., inpatient stay or hospital admission)
• Retrospective review – occurs after a service has already been provided.

Prior Authorization Required
Some *covered service expenses* (medical and behavioral health) 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. Receive 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 to by a *non-network provider.*

Prior Authorization (medical and behavioral health) requests must be received by phone/efax/ Provider portal as follows:

1. At least 5 days prior to an elective admission as an *inpatient* in a *hospital*, *extended care* or *rehabilitation facility*, or *hospice* facility.
2. At least 30 days prior to the initial evaluation for organ transplant services.
3. At least 30 days prior to receiving clinical trial services.
4. Within 24 hours of 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 reviews within 24 hours of receipt of the request.
3. For urgent *pre-service* reviews, within 72 hours from date of receipt of request.
4. For non-urgent *pre-service* reviews within 5 days, but no longer than 15 days, of receipt of the request.
5. For post-service or retrospective reviews, within 30 calendar days of receipt of the request.

How to Obtain Prior Authorization
To obtain *prior authorization* or to confirm that a *network provider* has obtained *prior authorization*, contact *us* by telephone at the telephone number listed on *your* health insurance identification card before the service or supply is provided to the *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. The medical expense has already been paid by someone else.
3. 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.

Prior Authorization Denials

Refer to the Complaint, Grievance and Appeal Procedures section of this contract for information on your right to appeal a denied authorization.

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*.

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

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

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 emergency 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*.

ACCESS TO CARE

Primary Care Provider
In order to obtain benefits, *you* must designate a *primary care provider* for each *member.* If you do not select a network primary care provider for each member, one will be assigned. *You* may select any *primary care provider* who is accepting new patients from any of the following provider types:
•Family practitioners
•General practitioners
•Internal medicine
•Nurse practitioners*
•Physician assistants
•Obstetricians/gynecologists
•Pediatricians (for children)
*If you choose a nurse practitioner as your PCP, your benefit coverage and copayment amounts are the same as they would be for services from other in-network providers. See your Summary of Benefits for more information.

Adults may designate an OB/GYN as a *primary care provider*. *You* may obtain a list of *primary care providers* at *our* website and using the "Find a Provider" function or by contacting *our* Member Services department.

You should get to know your PCP and establish a healthy relationship with them. Your PCP will:
•Provide preventive care and screenings
•Conduct regular physical exams as needed
•Conduct regular immunizations as needed
•Deliver timely service
•Work with other doctors when you receive care somewhere else
•Coordinate specialty care with Ambetter in-network specialists
•Provide any ongoing care you need
•Update your medical record, which includes keeping track of all the care that you get from all of your providers
•Treat all patients the same way with dignity and respect
•Make sure you can contact him/her or another provider at all times
•Discuss what advance directive are and file directives appropriately in your medical record.

Your network primary care provider will be responsible for coordinating all covered health services with other *network providers.* You may be required to obtain a referral from a primary care provider in order to receive care from a specialist provider. 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.

Changing Your Primary Care Physician (PCP)
You may change *your primary care provider for any reason, but not more frequently than once a month,* by submitting a written request, online at *our* website, www.ambetteroftennessee.com,or by contacting *our* office at the number shown on *your* identification card. The change to *your primary care provider* of record will be effective no later than 30 days from the date *we* receive *your* request.
Contacting Your Primary Care Physician
To make an appointment with your PCP, call his/her office during business hours and set up a date and time. If you need to cancel or change your appointment, call 24 hours in advance. At every appointment, make sure you bring your member ID card and a photo ID.

Should you need care outside of your PCP's office hours, you should call your PCP's office for information on receiving after hours care in your area. If you have an urgent medical problem or question or cannot

reach your PCP during normal office hours, call our 24/7 nurse advice line at 1-833-709-4735 (Relay 711). A licensed nurse is always available and ready to answer your health questions. In an emergency, call 911 or head straight to the nearest emergency room.

Non-Emergency Services
If *you* are traveling outside of the Ambetter of Tennessee *service area you* may be able to access *providers* in another state if there is an Ambetter plan located in that state. *You* can locate Ambetter *providers* outside of Tennessee by searching the relevant state in our Provider Directory at ProviderSearch.AmbetterHealth.com. Not all states have Ambetter plans. If *you* receive care from an Ambetter *provider* outside of the *service area*, *you* may be required to receive *prior authorization* for non-emergency services. Contact Member Services at the phone number on *your* ID card for further information.

Emergency Services Outside of Service Area
We cover emergency care services when you are outside of our service area.

If you are temporarily out of the service area and have a medical or behavioral health emergency, call 911 or go the nearest emergency room. Be sure to a call us and report your emergency within one business day. You do not need prior approval for emergency care services.

New Technology
Health technology is always changing. If we think a new medical advancement can benefit our members, we evaluate it for coverage. These advancements include:
- New technology
- New medical procedures
- New drugs
- New devices
- New application of existing technology

Sometimes, our medical director and/or medical management staff will identify technological advances that could benefit our members. The Clinical Policy Committee (CPC) reviews requests for coverage and decides whether we should change any of our benefits to include the new technology.

If the CPC does not review a request for coverage of new technology, our Medical Director will review the request and make a one-time determination. The CPC may then review the new technology request at a future meeting.

Network Availability
Your network is subject to change upon advance written notice. A *network service area* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, coverage will terminate. You may be eligible for a special enrollment period. Please contact the Health Insurance Marketplace for additional information.

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 of Tennessee provides coverage for healthcare services for a *member* and/or dependents. Some services require *prior authorization*. *Copayment* amounts must be paid to your *network provider* at the time you receive services. All *covered services* are subject to conditions, exclusions, limitations, terms, and provisions of this *Contract. Covered 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 of Tennessee will not pay benefits for any of the services, treatments, items or supplies that exceed benefit limits.

Ambulance Service Benefits

Covered service expenses will include ambulance services for local transportation:

1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury* in 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 a skilled nursing or *rehabilitation facility* when *authorized* by Ambetter of Tennessee.

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 (for example, transport-van, taxi).

Autism Spectrum Disorder Benefits

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

For purposes of this section, generally recognized services may include services such as:

- Evaluation and assessment services;
- *Applied behavior analysis* therapy;
- Behavior training and behavior management;

- Speech therapy;
- Occupational therapy;
- Physical therapy;
- Psychiatric care such as counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor or clinical social worker; and
- Medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

No limitation exists within the benefits for *applied behavior analysis* services. These services are subject to *prior authorization* to determine *medical necessity*. If multiple services are provided on the same day by different *providers*, a separate *copayment* and/or *coinsurance* will apply to each *provider*.

Diabetic Care

For *medically necessary* services and supplies used in the treatment of diabetes*. Covered service expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication. Benefits are available for *medically necessary* items of diabetic supplies and blood glucose monitors (including non-invasive monitors and monitors for the blind) for which a *medical practitioner* has written an order.

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 *our* habilitation equipment *specialist* or vendor should be done to estimate the cost of repair.
3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4. The equipment, supply, or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include the following:

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

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

Durable Medical Equipment

The rental (or, at *our* option, the purchase) of *durable medical equipment* prescribed by a *provider* or other *provider*. *Durable medical equipment* is equipment which can withstand repeated use; i.e. could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of *illness* or *injury*; and is appropriate for use in a patient's home. Examples include, but are not limited to, wheelchairs, crutches, *hospital* beds, and oxygen equipment. Rental cost must not be more than the purchase price. *We* 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 and supplies may include, but are not limited to:

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

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

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

See the *Schedule of Benefits* for benefit levels.

Medical and surgical supplies

Covered services include coverage for non-durable medical supplies and equipment for management of disease and treatment of medical and surgical conditions.

Covered services and supplies may include, but are not limited to:

1. Allergy serum extracts.
2. Chem strips, Glucometer, Lancets.
3. Clinitest.
4. Needles/syringes.
5. Ostomy bags and supplies, except charges such as those made by a Pharmacy for purposes of a fitting, are not *covered services*.

Exclusions:
Non-*covered services* and supplies include, but are not limited to:

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

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* and supplies may include, but are not limited to, the following:

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

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

Exclusions:
Non-*covered services* and supplies 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 specifically made and fitted (except as specified under Medical Supplies).
4. Garter belts or similar devices.

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 if:

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 and supplies 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. 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.
3. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
4. 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.
5. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
6. Restoration prosthesis (composite facial prosthesis).
7. 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).

Habilitation, 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*, filled by a licensed pharmacist, and 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 licensed practitioners.*
5. Outpatient physical therapy, occupational therapy, and physical therapy.

Cardiac *rehabilitation* is a *covered service.* However, cardiac rehabilitation services provided on a non-monitored basis and treatment for intellectual disability are excluded.

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

Covered services and supplies for *home health care* are limited to the following charges:

1. *Home health aide services*.
2. Services of a private duty registered nurse rendered on an outpatient basis.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
4. I.V. medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental or purchase of *medically necessary durable medical equipment* at the discretion of the plan. At our option, we may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider we authorize before the purchase
8. Sleep studies.

Charges under (4) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

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

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

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care under the Home Health Care Service Expense Benefit.

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* and supplies include:

1. Room and board in a *hospice* while the *member* is an *inpatient.*
2. Occupational therapy.
3. Speech-language therapy.

4. The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *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.*

Benefits for *hospice inpatient*, home and outpatient care are available for 5 days per episode.

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

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

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* to persons for use only while they are *inpatients.*
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 services* and supplies 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 *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint (including TMJ treatment Phase I)**.**
11. For reconstructive breast *surgery* charges as a result of a partial or total mastectomy. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas.

12. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the *Schedule of Benefits* for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *contract,* including the *deductible amount* and *percentage* provisions.
13. For the following types of tissue transplants:
    1. Cornea transplants.
    2. Artery or vein grafts.
    3. Heart valve grafts.
    4. Prosthetic tissue replacement, including joint replacements.
    5. Implantable prosthetic lenses, in connection with cataracts.
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. *Medically necessary services* made by a *provider* in an *urgent care center*, including facility costs and supplies.
16. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
17. Allergy testing.
18. Newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.
19. *Medically necessary telehealth services* subject to the same clinical and *utilization review* criteria, plan requirements, limitations and *cost sharing* as the same health care services when delivered to an insured in person.
20. For *medically necessary* genetic blood tests.
21. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
22. For *medically necessary* biofeedback services.
23. For *medically necessary* allergy treatment.
24. Therapeutic abortion performed to save the life or health of the *member*, or as a result of incest or rape.

Chiropractic Services

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.

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 potion, 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.

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 and substance use staff oversees the delivery and oversight of covered behavioral health and *substance use disorder* services for Ambetter. If *you* need mental health or *substance use disorder* treatment, *you* may choose any *provider* participating in *our* behavioral health and substance use *provider network* and do not need a referral from *your PCP* in order to initiate treatment. *You* can search for in-network Behavioral Health providers by using our Find a Provider tool at www.ambetteroftennessee.com or by calling Member Services at 1-833-709-4735 (Relay 711). *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 treatment of mental, emotional, and/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 and the most recent edition of the International Classification of Diseases.

When making coverage determinations, *our* behavioral health and substance use staff utilize 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 staff utilize Mckesson's Interqual criteria for mental health determinations and American Society of Addiction Medicine (ASAM) criteria for *substance use* determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

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

Inpatient

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

Outpatient

1. Evaluation and assessment for mental health and *substance use*;
2. Individual, group therapy, and marriage counseling for mental health and *substance use*;
3. Medication management services;
4. Outpatient detoxification programs;
5. Psychological and Neuropsychological testing and assessment;

6. Medication Assisted Treatment – combines behavioral therapy and medications to treat *substance use disorders*
7. *Applied Behavioral Analysis* for treatment of *autism spectrum disorders*;
8. *Telehealth*;
9. Partial Hospitalization Program (PHP);
10. Intensive Outpatient Program (IOP);
11. Mental health day treatment;
12. Electroconvulsive Therapy (ECT);
13. *Transcranial Magnetic Stimulation* (TMS); and
14. Assertive Community Treatment (ACT)

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

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

In addition, Integrated Care Management is available for all of your healthcare needs, including behavioral health and substance use. Please call 1-833-709-4735 (Relay 711) to be referred to a care manager for an assessment.

Other Dental Services

Anesthesia and *hospital* charges for dental care, for a *member* less than 19 years of age or a *member* who is physically or mentally disabled, are covered if the *member* requires dental treatment to be given in a *hospital* or outpatient ambulatory surgical facility. The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the *member's* condition under general anesthesia.

Outpatient Medical Supplies Expense Benefits

Covered services and supplies for outpatient medical supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including *medically necessary* repairs or replacement to restore or maintain a *member's* ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per year per *covered person*.
3. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
4. For the 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*.
7. For one hearing aid per ear, every three years.

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. Dilation;
    b. Refraction;
    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 www.ambetteroftennessee or call Member Services.

Services not covered:

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

Prescription Drug Expense Benefits

We work with providers and pharmacists to ensure that we cover medications used to treat a variety of conditions and diseases.

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

1. A *prescription drug.*
2. Prescribed, self-administered anticancer medication.
3. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *provider.*

4. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one (1) *standard reference compendium*; or
    b. The drug is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

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

Over-the-Counter (OTC) Prescriptions
We cover a variety of over-the-counter (OTC) medications when ordered by a physician. You can find a list of covered over-the-counter medications in our formulary – they will be marked as "OTC". Your prescription must meet all legal requirements.

How to Fill a Prescription
Prescription can be filled at an in-network retail pharmacy or through our mail-order pharmacy.

If you decide to have your prescription filled at an in-network pharmacy, you can use the Provider Directory to find a pharmacy near you. You can access the Provider Directory at www.ambetteroftennessee.com on the Find a Provider page. You can also call Member Services to help you find a pharmacy. At the pharmacy, you will need to provide the pharmacist with your prescription and your member ID card.

We also offer a three-month (90-day) supply of maintenance medications by mail or from in-network retail pharmacies for specific benefit plans. These drugs treat long-term conditions or illnesses, such as high blood pressure, asthma and diabetes. You can find a list of covered medications on www.ambetteroftennessee.com. You can also request to have a copy mailed directly to you.

Mail Order Pharmacy
If you have more than one prescription you take regularly, you may select to enroll in our mail order delivery program. Your prescriptions will be safely delivered right to your door at no extra charge to you. You will still be responsible for your regular copayment/coinsurance. To enroll for mail order delivery or for any additional questions, call our mail order pharmacy at 1-888-239-7690. Alternatively, you can fill out an enrollment form and mail the form to the address provided at the bottom of the form. The enrollment form can be found on our Ambetter website. Once on our website, click on the section, "For Member," "Pharmacy Resources." The enrollment form will be located under "Forms.
"

Formulary or Prescription Drug List
The formulary or prescription drug list is a guide to available generic and brand name drugs and some over-the-counter medications when ordered by a physician that are approved by the Food and Drug Administration (FDA) and covered through your prescription drug benefit. Generic drugs have the same active ingredients as their brand name counterparts and should be considered the first line of treatment. The FDA requires generics to be safe and work the same as brand name drugs. If there is no generic available, there may be more than one brand name drug to treat a condition. Preferred brand name drugs are listed on Tier 2 of the Drug List to help identify brand name drugs that are clinically appropriate, safe and cost effective treatment options, if a generic medication on the formulary is not suitable for your condition.

Please note, the formulary is not meant to be a complete list of the drugs covered under your prescription benefit. Not all dosage forms or strengths of a drug may be covered. This list is periodically reviewed and

updated and may be subject to change. Drugs may be added or removed or additional requirements may be added in order to approve continued usage of a specific drug.

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the formulary. For the most current Ambetter Formulary or Prescription Drug List or for more information about our pharmacy program, visit www.ambetteroftennessee.com (under "For Member", "Pharmacy Resources") or call Member Services at 1-833-709-4735 (Relay 711).

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

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 preventive 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 any one prescription or refill, or for some maintenance drugs up to 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply *network*. Specialty drugs and other select drug categories are limited to 30-day supply when dispensed by retail or mail order. Please note that only the 90 day supply is subject to the discounted *cost sharing*. Mail orders less than 90 days are subject to the standard *cost sharing* amount.;
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 travelling outside the United States, or those *you* purchase while residing 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 preventive treatment is related to member's vacation during out of country travel. This section does not prohibit coverage of treatment of aforementioned diseases.

15. Medications used for cosmetic purposes.
16. For infertility drugs unless otherwise listed on the formulary.
17. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
18. For drugs or dosage amounts determined by Ambetter to be ineffective, unproven, or unsafe for the indication for which they have been prescribed, regardless of whether such drugs or dosage amounts have been approved by any governmental regulatory body for that use.
19. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
20. For any drug dispensed from a non-lock-in pharmacy while *member* is in opioid lock-in program.
21. For any drug related to surrogate *pregnancy*, if the drug is reimbursed by a third party.
22. For any drug used to treat hyperhidrosis.
23. 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.
24. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
25. For any injectable medication or biological product that is not expected to be self-administered by the *member* at *member's* place of *residence* unless listed on the formulary.

Non-Formulary Prescription Drugs:
Under the Affordable Care Act, *yo*u have the right to request coverage of *prescription drug*s 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 or a protocol exception for step therapy. The request can be made in writing or via telephone. Within 72 hours of the request being received, *we* will provide the *member*, the *member's* designee or the *member's* prescribing *provider* with *our* coverage determination. Should the standard exception request or step therapy protocol exception request be granted, *we* will provide coverage of the non-formulary drug for the duration of the prescription, including refills, or of the drug that is the subject of the protocol exception.

Expedited exception request
A *member*, a *member's* designee or a *member's* prescribing *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 standard exception or step therapy protocol exception request be granted, *we* will provide coverage of the non-formulary drug or the drug that is the subject of the protocol exception for the duration of the exigency.

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

Lock-in program

To help decrease opioid overutilization and abuse, certain *members* identified through our Lock-in Program, may be locked into a specific pharmacy for the duration of their participation in the lock-in program. *Members* locked into a specific pharmacy will be able to obtain their medications(s) only at specified location. Amber 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.

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. Examples of these services are screenings for breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, prostate specific antigen testing, and screenings for child and adult obesity.
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual.
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.
5. Covers without *cost sharing*:
    a. Screening for *nicotine* or *tobacco use*; and
    b. For those who *use nicotine or tobacco* products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
        i. Four (4) nicotine or tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling, and individual counseling) without *prior authorization*; and
        ii. All Food and Drug Administration (FDA) approved nicotine or tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care *provider* without *prior authorization*.
6. Coverage for certain preventive care services that do one or more of the following:

a. Protect against disease;
b. Promote health; and or
c. Detect disease in its earliest stages before noticeable symptoms develop.

If a *member* and/or dependent(s) 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.

Benefits for preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any *deductible amounts, 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 non-preventive, *your* plan *copayment*, *coinsurance*, and *deductible* will apply. It's important to know what type of service *you're* getting. If a diagnostic or non-preventive service is performed during the same healthcare visit as a preventive service, *you* may have *copayment* and *coinsurance* charges.

Clinical Trial Coverage
Clinical Trial Coverage includes routine patient care costs incurred as the result of an approved phase I, II, III, or phase IV clinical trial and the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition. Coverage will include routine patient care costs incurred for (1) drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, (2) reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial and (3) all items and services that are otherwise generally available to a *qualified individual* that are provided in the clinical trial except:

- The investigational item or service itself;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Phase I and II clinical trials must meet the following requirements:

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

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

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

In a clinical trial, the treating facility and personnel must have the expertise and training to provide the

treatment and treat a sufficient volume of patients. There must be equal to or superior, non-investigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational alternatives.

Providers participating in clinical trials shall obtain a patient's informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.

Colorectal Cancer Examinations and Laboratory Tests
Covered service expenses include "colorectal cancer tests" for any non-symptomatic *covered person*, in accordance with the current American Cancer Society guidelines. *Covered service* includes tests for *covered persons* who are at least fifty (50) years of age; or less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

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 *deductible amounts*, *coinsurance* provisions, or *copayment amounts* to services when a *covered person* chooses not to use a high value service that is otherwise exempt from *deductible amounts*, *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 United States Secretary of Health and Human Services, but not later than one year after the recommendation or guideline is issued.

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

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*. An *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require prior *authorization*.

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

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

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

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

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

Duty to Cooperate
Members who are a *surrogate/gestational carrier* at the time of enrollment or *members* who agree to a *surrogacy/gestational carrier* arrangement during the plan year must, within 30 days of enrollment or agreement to participate in a *surrogacy/gestational carrier arrangement*, send us written notice of the *surrogacy/gestational carrier 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/gestational carrier* during the time that the *surrogate/gestational carrier* 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).

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

Note: This provision does not amend the *contract* to restrict any terms, limits, or conditions that may otherwise apply to *covered service expenses* for childbirth.

Newborn Charges
Medically necessary services, including *hospital* services, are provided for a covered newborn child immediately after birth. Each type of *covered service* incurred by the newborn child will be subject to his/her own *cost sharing* (*copayment, coinsurance* percentage, *deductible* and *maximum out-of-pocket amount*), as listed in the *Schedule of Benefits*. Please refer to the Dependent Member Coverage section of this document for details regarding Coverage for a Newborn Child/Coverage for an Adopted Child.

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

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

Prostate Specific Antigen Testing
Covered service expenses include "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for a *covered person* who is at least fifty (50) years of age; and at least

once annually for a *covered person* who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

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.

Radiology, Imaging and Other Diagnostic Testing

Medically necessary radiology services, imaging and tests performed for diagnostic reasons are a covered benefit (e.g., X-ray, MRI, CT scan, PET/SPECT, mammogram, ultrasound). *Prior authorization* may be required, see the *Schedule of Benefits* for details. Note: Depending on the service performed, two bills may be incurred - both subject to any applicable *cost sharing* - one for the technical component (the procedure itself) and another for the professional component (the reading/interpretation of the results by a *physician* or other qualified practitioner).

Emergency Room Services

In an emergency situation (anything that could endanger your life (or your unborn child's life)), you should call 911 or head straight to the nearest emergency room. We cover emergency medical and behavioral health services both in and out of our service area. We cover these services 24 hours a day, 7 days a week.

Please note some providers that treat you within the ER may not be contracted with Ambetter. If that is the case, they may balance bill *you* for the difference between our allowed amount and the provider's billed charge.

Infertility Services

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

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.

Social Determinants of Health Supplemental Benefits

Social determinants of health supplement 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 benefits upon obtaining coverage. The services are optional, and the benefits are made 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 www.ambetteroftennessee.com or by contacting Member Services at 1-833-709-4735 (Relay 711).

Transplant Services

Covered services for ttransplant service expenses:

Transplants are a covered benefit when a member is accepted as a transplant candidate and pre-*authorized* in accordance with this *contract*. *Prior authorization* must be obtained through the *"Center of Excellence",* before an evaluation for a transplant. *We* may require additional information such as testing and/or treatment before determining medical necessity for the transplant benefit. *Authorization* must be obtained prior to performing any related services to the transplant *surgery*. Transplant services must meet medical criteria as set by Medical Management Policy.

Cost share benefit coverage related to transplant services is available to both the recipient and donor of a covered transplant as follows:

1. If both the donor and recipient have coverage provided by the same insurer each will have their benefits paid by their own coverage program.
2. If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this contract will be provided for both you and the donor. In this case, payments made for the donor will be charged against enrollees benefits.
3. If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this contract will be provided for you. However, no benefits will be provided for the recipient.
4. If lapse in coverage due to non-payment of premium, no services related to transplants will be paid as a covered benefit.

If *we* determine that *an enrollee and donor are* is an appropriate candidate for a *medically necessary* transplant, live donation, *covered service expenses* will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting of the organ from the donor
3. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
4. Including outpatient covered services related to the transplant surgery, pre- transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection, and other immunosuppressive drug therapy, etc.
5. Pre-transplant stabilization, meaning an *inpatient* stay to *medically stabilize* a *member* to prepare for a later transplant, whether or not the transplant occurs.

6. The transplant itself, including the acquisition cost for the organ or bone marrow when authorized through the Center of Excellence and services are performed at participating facility.
7. Post-transplant follow-up visits and treatments.
8. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.
9. All costs incurred and medical expenses by the donor; shall be paid under the transplant recipient policy, this excludes travel, lodging, food, mileage. Please see transplant travel expense policy for outlined details on reimbursement limitations. (www. Ambetter.com).

These medical expenses are covered to the extent that the benefits remain and are available under the *enrollee's contract*, after benefits for the *enrollee's* own expenses have been paid. In the event of such coverage, the otherwise existing coverage of a live donor shall be secondary to benefits under the *enrollee's contract*.

Ancillary "*Center Of Excellence*" Service Benefits:
An *enrollee* may obtain services in connection with a transplant from any *physician*. However, if a transplant is performed in a *Center of Excellence:*

1. *We* will pay for the following services when the *enrollee* is required to travel more than 75 miles from the *residence* to the *Center of Excellence*:
2. *We* will pay a maximum of $10,000 per transplant for the following services:
    a. Transportation for the *enrollee,* any live donor, and the *immediate family* to accompany to and from the *Center of Excellence* in the United States*.*
    b. When enrollee and/or donor is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
    c. Maximum reimbursement for mileage is limited to travel to and from the member's home to the transplant facility, and to and from the donor's home to the transplant facility, and will be reimbursed at the current IRS mileage standard for miles driven for medical purposes.
    d. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *enrollee* while the *enrollee* is confined in the *Center of Excellence* in the United States*. We* will pay the costs directly for transportation, lodging, and any of the following approved items listed in the member transplant guidelines. However, *you* must make the arrangements and provide the necessary paid receipts for reimbursement within 6 months of the date of service in order to be reimbursed.
    e. Incurred costs related to a certified/registered service animal for the transplant enrollee and/or donor.
    f. Please refer to the member resources page for member reimbursement transplant travel forms and information at www. Ambetter.com.

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these Transplant Service Expense Benefits:

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the Center of Excellence.
4. To keep a donor alive for the transplant operation, except when authorized through the Center of Excellence..

5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
6. Related to transplants unauthorized though the Center of Excellence and is not included under this provision as a transplant.
7. For a transplant 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.
8. The acquisition cost for the organ or bone marrow, when provided at an unauthorized facility or not obtained through the Center of Excellence.
9. For any transplant services and/or travel related expenses for enrollee and donor, when preformed outside of the United States.
10. The following ancillary items listed below, will not be subject to member reimbursement under this policy:

    a. Alcohol/tobacco
    b. Car Rental (unless pre-approved by Case Management)
    c. Vehicle Maintenance for motorized and hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, ect.)
    d. Parking, such as but not limited to hotel, valet or any offsite parking other than hospital.
    e. Storage rental units, temporary housing incurring rent/mortgage payments.
    f. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, ect.
    g. Speeding tickets
    h. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
    i. For any services related to pet care, boarding, lodging, food, and/or travel expenses; other than those related to certified/registered service animal(s).
    j. Expenses for persons other than the patient and his/her covered companion
    k. Expenses for lodging when member is staying with a relative
    l. Any expense not supported by a receipt
    m. Upgrades to first class travel (air, bus, and train)
    n. Personal care items (e.g., shampoo, deodorant, clothes)
    o. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA precheck, and early check-in boarding fees, extra baggage fees.
    p. Souvenirs (e.g., t-shirts, sweatshirts, toys)
    q. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type.
    r. All other items not described in the policy as eligible expenses
    s. Any fuel costs / charging station fees for electric cars.

Organ Transplant Medication Notification

At least 60 days prior to making any formulary change that alters the terms of coverage for a patient receiving *immunosuppressant drugs* or discontinues coverage for a prescribed immunosuppressant drug that a patient is receiving, *We* must, to the extent possible, notify the prescribing *physician* and the patient, or the parent or guardian if the patient is a child, or the *spouse* of a patient who is *authorized* to consent to the treatment of the patient. The notification will be in writing and will disclose the formulary change, indicate that the prescribing *physician* may initiate an appeal, and include information regarding the procedure for the prescribing *physician* to initiate the *contract*'s appeal process.

As an alternative to providing written notice, *we* may provide the notice electronically if, and only if, the patient affirmatively elects to receive such notice electronically. The notification shall disclose the formulary change, indicate that the prescribing *physician* may initiate an appeal, and include information

regarding the procedure for the prescribing *physician* to initiate the *contract*'s appeal process.

At the time a patient requests a refill of the immunosuppressant drug, *we* may provide the patient with the written notification required above along with a 60-day supply of the immunosuppressant drug under the same terms as previously allowed.

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

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. These programs may include a reward or an incentive, which you may earn by completing different activities.

If you have a medical condition that may prohibit you from participating in these programs, we may require you to provide verification, such as an affirming statement from your physician, that your medical condition makes it unreasonably difficult or inadvisable to participate in the wellness or health improvement program, in order for you to receive the reward or incentive.

You may obtain information regarding the particular programs available at any given time by visiting our website at www.ambetteroftennessee.com or by contacting Member Service by telephone at 1-833-709-4735 (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 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.

Care Management Programs

We understand special health needs and are prepared to help you manage any that you may have. Our Care Management services can help with complex medical or behavioral health needs. If you qualify for Care Management, we will partner you with a care manager. Care managers are registered nurses or social workers that are specially trained to help you:

- Better understand and manage your health conditions
- Coordinate services
- Locate community resources

Your care manager will work with you and your doctor to help you get the care you need. If you have a severe medical condition, your care manager will work with you, your primary care provider (PCP) and other providers to develop a care plan that meets your needs and your caregiver's needs .

If you think you could benefit from our Care Management program, please call Member Services at 1-833-709-4735 (Relay 711).

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, except for expenses incurred in connection with individual or group *hospital*, medical or surgical policy issued, delivered, amended or renewed on or after March 17, 1982, or employer or other entity that administers health, medical, or surgical insurance or that has an insurance company administering its health services program, shall except, limit, or reduce benefits or otherwise fail to pay for services rendered by a non-governmental charitable research *hospital*.
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 by a *member* of 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*.
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*, bariatric *surgery* and weight loss programs, except as specifically covered in the Major Medical Expense Benefits section of the *contract*.
4. For the reversal of sterilization and the reversal of vasectomies.
5. For non-therapeutic abortion.
6. For expenses for television, telephone, or expenses for other persons.
7. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
8. For telephone consultations, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
9. For stand-by availability of a *medical practitioner* when no treatment is rendered.
10. For *dental service* expenses*,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits.
11. 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.

12. For the treatment of infertility except as expressly provided in this *contract*.
13. Mental health services are excluded:
    a. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
    b. Pre-marital counseling;
    c. Court-ordered care or testing, or required as a condition of parole or probation. Benefits will be allowed for services that would otherwise be covered under this policy;
    d. Testing of aptitude, ability, intelligence or interest; and
    e. Evaluation for the purpose of maintaining employment.
14. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
15. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
16. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
17. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
18. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.
19. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
20. For hearing aids, 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 ninety (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, 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. For or related to treatment of hyperhidrosis (excessive sweating).
25. For fetal reduction *surgery*.
26. Except as specifically identified as a *covered service expense* under the *contract*, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
27. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or Semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any motorized vehicle or conveyance (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).

28. 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.
29. 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.
30. For the following miscellaneous items: Artificial Insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-*covered services*; 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; *rehabilitation* services for the enhancement of job, athletic, or recreational performance; routine or elective care outside the *service area*; sclerotherapy for varicose veins; treatment of spider veins; transportation expenses, unless specifically described in this *contract*.
31. Diagnostic testing, laboratory procedures screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
32. For court ordered testing or care unless *medically necessary*.
33. For a *member's illness* or *injury* which 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,* which is designated for medical expenses*.*
34. For any claim submitted by non lock-in pharmacy while *member* is in lock-in status. To facilitate appropriate benefit use and prevent opioid overutilization, member's participation in lock-in status will be determined by review of pharmacy claims.
35. For any medicinal and recreational use of cannabis or marijuana.
36. *Surrogacy/Gestational Carrier Arrangement.* The following health care services, including related supplies and medication, to a Member serving as a *surrogate/gestational carrier are excluded:*
    a. Mental health services related to the *surrogacy/gestational carrier arrangement*;
    b. Expenses relating to donor semen, including collection and preparation for implantation;
    c. Donor gamete or embryos or storage of same relating to a *surrogacy/gestational carrier arrangement*;
    d. Use of frozen gamete or embryos to achieve future conception in a *surrogacy/gestational carrier arrangement*;
    e. Preimplantation genetic diagnosis relating to a *surrogacy/gestational carrier arrangement*; or
    f. Any complications of the child resulting from the *pregnancy*;
    g. Any other non-maternity care services, supplies and medication
    h. 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 insured's possessing an active policy with *us* and/or the child possesses an active policy with *us* at the time of birth.

    The following health care services, including supplies and medication to a non-covered person serving as a *surrogate/gestational carrier* pursuant to a *surrogacy/gestational carrier arrangement* with a *member* are excluded. This exclusion applies to all health care services, supplies and medication to the non-covered *surrogate/gestational carrier* 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/gestational* carrier following childbirth);

d. Mental Health Services related to *the surrogacy/gestational carrier arrangement*;
e. Expenses related to donor semen, including collection and preparation for implantation;
f. Donor gamete or embryos or storage of same relating to a *surrogacy/gestational carrier arrangement*;
g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy/gestational carrier arrangement*;
h. Preimplantation genetic diagnosis relating to a *surrogacy/gestational carrier arrangement*;
i. Any complications of the *surrogate/gestational carrier* resulting from the *pregnancy*; or
j. Any other health care services, supplies and medication relating to the *surrogacy/gestational carrier arrangement*.

Any and all health care services, supplies or medication provided to any child birthed by a *surrogate/gestational carrier* as a result of a *surrogacy/gestational carrier arrangement* are also excluded. This exclusion shall not apply where a *member* possessing an active policy with us is the intended parent of the child 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, or if *you* are enrolled through the Health Insurance Marketplace, the date of termination that the Health Insurance Marketplace provides *us* upon *your* request of cancellation to the Health Insurance Marketplace;
3. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision;
4. The date of *your* death, if this *contract* is an Individual Plan;
5. The date a *member's* eligibility for coverage under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*; or
6. 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.

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 policies issued on this form, for all residents of the state where *you* reside, *we* will provide a written notice to *you* at least 90 days prior to the date that *we* discontinue coverage. *You* will be offered an option to purchase any other coverage in the individual market *we* offer in *your* state at the time of discontinuance of this *policy*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

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

Notification Requirements
It is the responsibility of *you* or *your* former *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.

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 payment from any *third party,* which is designated for medical expenses. 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 for a medical expense.
    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; the *third party's* payment must be 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* in relation to their claim.

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.

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.

COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

Internal Review

Complaints
Basic elements of a *complaint* include:

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

Grievances
Ambetter of Tennessee has a *grievance* procedure which allows you the opportunity to resolve your issues and *complaints*. The process is voluntary and is available for review of the policy, quality of care or quality of service issues that affect you. The *grievance* process does not apply to *grievance*s based solely on the basis that the policy does not cover the service or limits benefits for the health care service in question, provided that the exclusion of the specific service requested is clearly stated in the *policy.*

Grievances are normally, but not limited to, the following concerns:

1. Availability, delivery or quality of health care services;
2. Matters pertaining to the contractual relationship between a *covered person* and Ambetter of Tennessee;
3. Matters pertaining to the contractual relationship between a health care *provider* and Ambetter of Tennessee; and
4. Contract reformation or amendment disputes.

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.

Claimants should submit all documentation to us at:
Ambetter of Tennessee

Attn: Grievances and Appeals Department, 3rd fl
12515-8 Research Blvd, Suite 400
Austin, TX 78759

Fax: 1-833-886-7956

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

An eligible Complainant is:

1. A member*;*
2. Person authorized to act on behalf of the member. **Note:** Written authorization is required;
3. In the event the *member* 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* reviews are appeals and not *grievances,* and will follow standard state and federal guidelines.

Filing a Grievance:
Grievances may be requested by a member, the member's *authorized representative* or a *provider* acting on behalf of a member. *Grievances* may be filed orally by calling 1-833-709-4735 (Relay 711), but must be followed up in writing by mailing a letter or the Grievance and Appeal Form from our website, along with copies of any supporting documents to

Ambetter of Tennessee
Attn: Grievance and Appeals Department
12515-8 Research Blvd., Suite 400
Austin, TX 78759

Grievance Review:
The *grievance* review is for standard, non-urgent issues and *complaints*. A *grievance* may be submitted in writing by *you*, *your authorized representative* or *your provider* acting on your behalf. Within 5 business days of receiving a *grievance*, Ambetter of Tennessee, will provide *you* with the name, address and telephone number of the person coordinating the review and instructions on submitting supporting documents, including the address to which such material may be submitted.

Resolution Timeframes:
Ambetter of Tennessee will issue a written decision, in clear terms, to *you* and *your authorized representative*, if applicable, within 30 days after receiving the *grievance*. Ambetter of Tennessee may extend the timeframe for disposition of a *grievance* for up to 14 calendar days if the *member* requests the extension or if the *member* gives consent.

Acknowledgement:
Within 5 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 health care information or medical records may be disclosed only if permitted by law.

1. The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose;

2. If such disclosure is prohibited by law, health care information or medical records may be withheld from an *authorized representative*, including information contained in its resolution of the *grievance*; and
3. A *grievance* submitted by an *authorized representative* will be processed regardless of whether health care information or medical records may be disclosed to the *authorized representative* under applicable law.

Right to Participate:
A *claimant* or the *claimant's authorized representative*, who has filed a *grievance* has the right to submit comments to the Grievance and Appeals Administrator that is responsible for the resolution of the *grievance*. The *claimant* or *authorized representative* is entitled to request a copy of documentation reviewed by the Grievance and Appeals Administrator in making its determination. The *claimant* must submit questions or comments to the Grievance and Appeals Administrator or external review organization in writing within a period of time provided in the notice to the *claimant* of the *grievance* process.

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.

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.

Written Grievance Response:
Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reasons for the denial, determination, or initiation of disenrollment.
Our written determination to the *claimant* must include:

1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *grievance*;
3. A written description of position titles of the persons involved in making the decision.
4. A clear explanation of the decision;
5. Reference to the specific plan provision on which the determination is based;
6. 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; and
7. 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.

Appeals
When *we* deny a claim for a treatment or service, a claim for plan benefits *you* have already received (*post-service claim* denial) or *we* deny your request to authorize treatment or service (pre service denial), *our* decision is known as an *adverse benefit determination*. You, your *physician* or *authorized representative* can request an *appeal* of *our* decision. If *we* rescind *your* coverage or deny *your* application for coverage, *you* may also *appeal our* decision. When *we* receive *your appeal*, *we* are required to review *our* own decision.

Appeals must be filed in writing by *you*, *your authorized representative* or *your provider* acting on *your* behalf by filing the Grievance and Appeals form from our website or by mailing a written *appeal* along with copies of any supporting documents to:

Ambetter of Tennessee
Attn: Grievances and Appeals Department
12515-8 Research Blvd., Suite 400
Austin, TX 78759

Right to Participate:
A *member* or the *member's authorized representative*, who has filed an *appeal* has the right to submit written comments, documents, records and other information to the Grievance and Appeals Department. The *member* or *member's authorized representative* is entitled to request a copy of the documentation reviewed by the Grievance and Appeals Department in making its determination. The *member* must submit questions or comments to the Grievance and Appeals Department in writing within a period of time provided in the notice to the *member* of the *appeals* process.

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

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

Rescission of coverage:
If the plan rescinds *your* coverage, *you* may file an *appeal* of that determination. The plan cannot terminate *your* benefits until *your appeal* rights have been exhausted. Since a *rescission* means that no coverage ever existed, if the plan's decision to rescind is upheld, *you* will be responsible for payment of all claims for *your* health care services.

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

Acknowledgement:
Within 5 business days of receipt of an *appeal*, a written acknowledgment to the member, the *provider* or the member's *authorized representative* confirming receipt of the *appeal* must be delivered or deposited in the mail.

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

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

Resolution Timeframes:
Appeals will be resolved and we will notify you in writing with the *appeal* decision within the following timeframes:

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

In general, Ambetter of Tennessee may seek your approval to extend the time for providing a decision on post-service claims for 14 days after the expiration of the initial period, or if the plan determines that such an extension is necessary for reasons beyond the control of the plan. There is no provision for extensions in the case of claims involving urgent care or *expedited appeals*.

A *member* shall be provided, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the *member's* claim for benefits. All comments, documents, records and other information submitted by the *member* relating to the issue or 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 *member* will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The plan will give the *member* 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 *member* will have the option of delaying the determination for a reasonable period of time to respond to the new information; or
2. The *member* will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer. The plan will give the *member* 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 *member* will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.

Emergency medical services:
If the plan denies a claim for an *emergency* medical service, *your appeal* will be handled as an *expedited appeal*. The plan will advise *you* at the time it denies the claim that *you* can file an *expedited appeal*. If *you* have filed for an *expedited appeal*, *you* may also file for an expedited external review (see 'Simultaneous urgent claim, *expedited appeal* and external review").

Expedited Appeal:

Expedited appeal means *appeal* 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 *appeal*.

An *expedited appeal* may be submitted orally or in writing. All necessary information, including *our* determination on review, will be transmitted between the *member* and *us* by telephone, facsimile, or other available similarly expeditious method. An *expedited appeal* shall be resolved as expeditiously as the *claimant's* health condition requires, but not more than 72 hours after receipt of the *appeal*.

If the *expedited appeal* involves an adverse determination with respect to a concurrent review of an urgent care request, the service shall be continued until the *covered person* or covered person's *authorized*

representative has been notified of the determination or until the healthcare *provider* determines that the urgent care is no longer appropriate or necessary. This does not apply to requests for extensions.

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

Simultaneous *expedited appeal* and external review:
You or your *authorized representative*, may request an *expedited appeal* and an expedited external review (see External Review provision) if both the following apply:

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

Written Appeal Response:
Appeal response letter (*final adverse determinations*) will be written in a manner to be understood by *you* and the notification shall include the specific reasons for the denial, determination, or initiation of disenrollment.

Our written *final adverse determination* of the *appeal* will include:

1. The disposition of and the specific reason or reasons for the decision in clear terms and the medical rationale for the decision, if applicable
2. Any corrective action taken on the *appeal*;
3. The titles and qualifying credentials of the persons involved in making the decision;
4. A statement of the reviewer's understanding of the issues;
5. Reference to the evidence or documentation used as the basis for the decision
6. Reference to the specific plan or *contract* provision on which the determination is based;
7. A statement that the *member* 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 *member's* issue;
8. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the *adverse benefit 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 benefit determination* and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the *member* upon request;
9. If the *adverse benefit determination* is based on *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 *member's* medical circumstances or a statement that such explanation will be provided free of charge upon request;
10. A description of the procedures for obtaining an external review of the *final adverse determination*; and
11. If applicable:
    a. 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*;
    b. The date of service;
    c. The health care *provider's* name;
    d. The claim amount;

e. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
f. Ambetter of Tennessee's denial code with corresponding meaning;
g. A description of any standard used, if any, in denying the claim;
h. A description of the external review procedures, if applicable;
i. The right to bring a civil action under state or federal law;
j. A copy of the form that authorizes Ambetter of Tennessee to disclose protected health information, if applicable;
k. That assistance is available by contacting the Tennessee Department of Commerce and Insurance, if applicable; and
l. A culturally linguistic statement based upon the *member's* county or state of *residence* that provides for oral translation of the *adverse benefit determination*, if applicable.

External Review:
An external review is conducted by an *Independent Review Organization* (IRO) that will review the final *appeal* decision and render a decision on whether to uphold or reverse the *adverse benefit determination.* An external review decision is binding on *us*. An external review decision is binding on the *claimant* except to the extent the *claimant* has other remedies available under applicable federal or state law.

We will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility
The external review procedures apply to:

1. Any *hospital* or medical policy or certificate; excluding accident only or disability income only insurance; or
2. Conversion plans.

An external review is available for *appeals* that involve:

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

External Review Procedure
After exhausting the internal review process, the *claimant* has six months to make a written request to the Grievance and Appeals Administrator 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 appeal* or *we* either provide a waiver of this requirement or fail to follow the *appeal* process;
2. A health plan must allow a *claimant* to make a request for an expedited external review with the plan at the time the *claimant* receives:
    a. An *adverse benefit determination* if the determination involves a medical condition of the *claimant* for which the timeframe for completion of an internal *expedited appeal* would seriously jeopardize the life or health of the *claimant* or would jeopardize the *claimant's* ability to regain maximum function and the *claimant* has filed a request for an internal *expedited appeal*; and
    b. A final internal *adverse benefit determination*, if the *claimant* has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the *claimant* or would jeopardize the *claimant's* ability to regain maximum function, or if the final internal *adverse benefit determination* concerns an admission,

availability of care, continued stay, or health care item or service for which the *claimant* received *emergency* services, but has not been discharged from a facility; and

3. *Claimants* may request an expedited external review at the same time the internal *expedited appeal* is requested (see procedures below).

External Review Process

1. *We* have 10 business days (immediately for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether:
    a. The individual was a *covered person* at the time the item or service was requested;
    b. The service is a *covered service* under the *claimant's* health plan but for the plan's *adverse benefit determination* with regard to medical necessity experimental/investigational, medical judgment, or *rescission*;
    c. The *claimant* has exhausted the internal process; and
    d. The *claimant* has provided all of the information required to process an external review.
2. Within 3 business days (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 six month filing period or within the 48-hour period following the receipt of notification;
4. *We* will assign an IRO on a rotating basis from *our* list of contracted IROs;
5. Within 6 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. Within 3 business days, the assigned IRO will timely notify the *claimant* in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the *claimant* may submit in writing additional information to the IRO to consider;
8. Upon receipt of any information submitted by the *claimant*, the IRO must forward the information to *us* within 1 business day;
9. Upon receipt of the information, *we* may reconsider *our* determination. If *we* reverse *our adverse benefit determination*, *we* must provide written notice of the decision to the *claimant* and the IRO within 1 business day after making such decision. The external review would be considered terminated;
10. Within 40 days after the date of receipt of the request for an external review by the health plan, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to *us* within 1 business *day* of reaching its decision. We will then notify you of the IRO's decision within 3 business days.
11. 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; and
12. 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.*

Expedited External Review:

An external *expedited appeals* may be submitted orally or in writing. All necessary information will be transmitted between the *claimant* and *us* by telephone, facsimile, or other available similarly expeditious method and given by us to the IRO.

Ambetter will allow a *member* to make a request for an expedited external review with the plan at the time the *member* receives:

a. An *adverse benefit determination* if the determination involves a medical condition of the *member* for which the timeframe for completion of an internal *expedited appeal* would seriously jeopardize the life or health of the *member* or would jeopardize the *member's* ability to regain maximum function and the *member* has filed a request for an internal *expedited appeal*; and
b. A final internal adverse benefit determination, if the *member* has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the *member* or would jeopardize the *member 's* ability to regain maximum function, or if the final internal *adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service for which the *member* received emergency services, but has not been discharged from a facility.

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

Appeals and Grievances filing and key communication timelines:

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard Grievance	N/A	5 Calendar Days	30 Calendar Days	14 Calendar Days
Standard Pre-Service Appeal	180 Calendar Days	5 Calendar Days	30 Calendar Days	14 Calendar Days
Expedited Pre-Service Appeal	180 Calendar Days	N/A	72 Hours	N/A
Standard Post-Service Appeal	180 Calendar Days	5 Calendar Days	60 Calendar Days	14 Calendar Days
External Review	6 Months	Up to 13 Calendar Days	45 Calendar Days	N/A
Expedited External Review	6 Months	Immediately	72 Hours	N/A

You can also view your appeal and grievance information in your member secure portal.

Further Resources
The Tennessee Department of Commerce & Insurance is available to assist insurance consumers with insurance related problems and questions. *You* may inquire in writing at Consumer Insurance Services, 500 James Robertson Parkway, 10th Floor, Nashville, Tennessee 37243-0574 or contact the Department between the hours of 8 a.m. to 5 p.m. CST at 1-800-342-4029.

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.

How to Submit a Claim
Providers will typically submit claims on your behalf, but sometimes you may need to submit claims yourself for covered services. This usually happens if:

- Your provider is not contracted with us
- You have an out-of-are emergency.

If you have paid for services we agreed to cover, you can request reimbursement for the amount you paid. We can adjust your deductible, copayment or cost sharing to reimburse you.

To request reimbursement for a covered service, you need a copy of the detailed claim from your provider. You also need to submit an explanation of why you paid for the covered services along with the member reimbursement claim form posted at www.ambetteroftennessee.com under "Member Resources". Send all the documentation to us at the following address:

Ambetter of Tennessee
Attn: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

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

1. Sign, date, and deliver to us *authorizations* to obtain any medical or other information, records or documents *we* deem relevant from any person or entity.
2. Obtain and furnish to *us*, or *our* representatives, any medical or other information, records or documents *we* deem relevant.
3. Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask.
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 *policy*.

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 the claim at issue to the *member*.

Time for Payment of Claims
Benefits will be paid within 30 days for clean claims on paper; electronic claims will be paid within 21 days. "Clean claims" means a claim submitted by *you* or a *provider* that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If *we* have not received the information *we* need to process a claim, *we* will ask for the additional information necessary to complete the claim. *You* will receive a copy of that request for additional information. In those cases, *we* cannot complete the processing of the claim until the additional information requested has been received. *We* will make *our* request for additional information within 20 days of *our* initial receipt of the claim and will complete *our* processing of the claim within 30 days after *our* receipt of all requested information.

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*.

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
We will reimburse a *hospital* or health care *provider* if:

1. *Your* health insurance benefits are assigned by *you* in writing; and
2. *We* approve the assignment.

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

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.

Medicare
This provision describes how *we* coordinate and pay benefits when a *member* is also enrolled in Medicare and duplication of Coverage occurs. If a *member* is not enrolled in Medicare or receiving benefits, there is no duplication of Coverage and *we* do not have to coordinate with Medicare.

The benefits under this *contract* are not intended to duplicate any benefits to which *members* are entitled under Medicare.

Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status, and will be adjudicated by us as set forth in this section. In cases where Medicare or another

government program has primary responsibility, Medicare benefits will be taken into account for any *member* who is enrolled for Medicare. This will be done before the benefits under this *health plan* are calculated. 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.
Charges for services used to satisfy a *member's* Medicare Part B *deductible* will be applied in the order received by *us*. Two or more expenses for services received at the same time will be applied starting with the largest first.

This provision will apply to the maximum extent permitted by federal or state law. *We* will not reduce the benefits due any *member* because of a *member's* eligibility for Medicare where federal law requires that *we* determine its benefits for that *member* without regard to the benefits available under Medicare.

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

Medicaid Reimbursement
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.

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,* but was not eligible.

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

Personal Health Information (PHI)
Your health information is personal. We are committed to do everything we can to protect it. Your privacy is also important to us. We have policies and procedures in place to protect your health records.

We protect all oral, written and electronic PHI. We follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. We are required to notify you about these practices every year. This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. If you need more information or would like the complete notice, please visit https:// www.ambetteroftennessee.com /privacy-practices.html or call Member Services at 1-833-709-4735 (Relay 711).

We protect all of your PHI. We follow HIPAA to keep your healthcare information private.

Language
If you don’t speak or understand the language in your area, you have the right to an interpreter. For language assistance, please visit: https:// www.ambetteroftennessee.com /language-assistance.html.

Statement of Non-Discrimination

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

Ambetter of Tennessee:

- 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 of Tennessee at 1-833-709-4735 (Relay 711).

If you believe that Ambetter of Tennessee has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a *grievance* with: Ambetter of Tennessee, ATTN: Ambetter Grievances and Appeals Department, 12515-8 Research Blvd, Suite 400, Austin, TX 78759, 1-833-709-4735 (Relay 711), Fax: 1-833-886-7956. You can file a *grievance* by mail or fax. If you need help filing a *grievance*, Ambetter of Tennessee is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

Declaración de no discriminación

Ambetter de Tennessee 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 Tennessee no excluye personas o las trata de manera diferente debido a su raza, color, origen nacional, edad, discapacidad, o sexo.

Ambetter de Tennessee:

- 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 of Tennessee at 1-833-709-4735 (Relay 711)

Si considera que Ambetter de Tennessee no le ha proporcionado estos servicios, o en cierto modo le ha discriminado debido a su raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja ante: Ambetter of Tennessee, ATTN: Ambetter Grievances and Appeals Department, ATTN: Grievances and Appeals Department, 12515-8 Research Blvd, Suite 400, Austin, TX 78759, 1-833-709-4735 (Relay 711), Fax: 1-833-886-7956. Usted puede presentar una queja por correo, fax, o correo electrónico. Si necesita ayuda para presentar una queja, Ambetter of Tennessee está disponible para brindarle ayuda. También puede presentar una queja de violación a sus derechos civiles ante la Oficina de derechos civiles del Departamento de Salud y Servicios Humanos de Estados Unidos (U.S. Department of Health and Human Services), en forma electrónica a través del portal de quejas de la Oficina de derechos civiles, disponible en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, o por correo o vía telefónica llamando al: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter of Tennessee, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-709-4735 (Relay 711).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter of Tennessee، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل ب [1-833-709-4735 (Relay 711).]
Chinese:	如果您，或是您正在協助的對象，有關於Ambetter of Tennessee,方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話1-833-709-4735 (Relay 711).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter of Tennessee, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-833-709-4735 (Relay 711).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Ambetter of Tennessee,에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는[1-833-709-4735 (Relay 711) 로 전화하십시오.
French:	Si vous-même ou une personne que vous aidez avez des questions à propos Ambetter of Tennessee, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-833-709-4735 (Relay 711).
Laotian:	ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ Ambetter from Tennessee, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-833-709-4735 (Relay 711).
Amharic:	እርስዎ ወይም እርሰዎ የሚረዱት ሰው ስለ Ambetter of Tennessee, ግብር ጥያቄ ካለዎት ያለምንም ወጪ በቋንቋዎ ድጋፍ እንዲሁም መረጃ የማግኘት መብት አለዎት፤ ፤ አስተርጓሚ ለማነጋገር በ 1-833-709-4735 (Relay 711). ይደውሉ፤ ፤
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter of Tennessee, hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-833-709-4735 (Relay 711)an.
Gujarati:	જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter of Tennessee, વિશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-833-709-4735 (Relay 711) ઉપર કોલ કરો.
Japanese:	Ambetter of Tennessee, について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-833-709-4735 (Relay 711). までお電話ください。
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter of Tennessee, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-833-709-4735 (Relay 711).
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter of Tennessee, के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-833-709-4735 (Relay 711). पर कॉल करें।
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter of Tennessee, вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-833-709-4735 (Relay 711).
Persian:	اگر شما، یا کسي که به او کمک مي کنيد سؤالي در مورد Ambetter of Tennesseeداريد، از اين حق برخورداريد که کمک و اطلاعات را بصورت رايگان به زبان خود دريافت کنيد. براي صحبت کردن با مترجم با شماره 1-833-709-4735 (Relay 711). تماس بگيريد.