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2021 Evidence of Coverage

Ambetter.ARhealthwellness.com

70525AR007.QCA

AMBETTER FROM ARKANSAS HEALTH AND WELLNESS

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

Major Medical Expense Insurance Policy

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

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

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

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

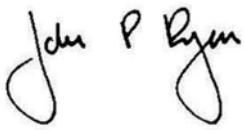
Annually, *we* may change the rate table used for this *policy* form. Each premium will be based on the rate table in effect on that premium's due date. The *policy* plan, and age of *covered persons,* type and level of benefits, and place of *residence* on the premium due date are some of the factors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

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

This *policy* contains *prior authorization* requirements. Benefits may be reduced or not covered if the requirements are not met. Please refer to the *Schedule of Benefits* and the *Prior Authorization* Section.

You are required to enroll each year in order to receive any subsidies for which *you* may be eligible.

QCA Health Plan, Inc.



John Ryan
President and CEO

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INTRODUCTION

Welcome to Ambetter from Arkansas Health & Wellness! *We* have prepared this *policy* to help explain *your* coverage. Please refer to this *policy* whenever *you* require medical services. It describes:

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

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

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

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

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

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

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

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

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

You have the right to:

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

12. Be kept informed of *covered* and non-*covered services*, program changes, how to access services, *primary care provider* assignment, *providers*, advance directive information, *authorizations*, benefit denials, *member* rights and responsibilities, and *our* other rules and guidelines.
13. A current list of *network providers*.
14. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
15. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, sex, sexual orientation, national origin or religion.
16. Access *medically necessary* urgent and *emergency services* 24 hours a day and seven days a week.
17. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
18. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *primary care provider*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care provider*. *Your primary care provider* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
19. Select *your primary care provider* within the *network*. *You* also have the right to change your *primary care provider* or request information on *network providers* close to your home or work.
20. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care provider*.
21. An interpreter when *you* do not speak or understand the language of the area.
22. A second opinion by a *network provider* if *you* want more information about *your* treatment or would like to explore additional treatment options.
23. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it.
24. Advance directives are forms *you* can complete to protect *your* rights for *medical care*. It can help your *primary care provider* and other *providers* understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
    a. Living Will;
    b. HealthCare Power of Attorney; and
    c. "Do Not Resuscitate" Orders. *Members* also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this entire *policy*.
2. Treat all *healthcare professionals* and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of your *provider* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* I.D. card and keep scheduled appointments with *your provider*, and call the *provider's* office during office hours whenever possible if *you* have a delay or cancellation.

6. Know the name of *your* assigned *primary care provider*. *You* should establish a relationship with *your physician*. *You* may change *your primary care provider* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your healthcare professionals* and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* or *your healthcare professionals* and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your healthcare professionals* and *physician*.
11. Tell *your healthcare professional* and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care provider* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care provider*.
14. Provide all information about any other medical coverage *you* have upon enrollment in this plan. If, at any time, *you* get other medical coverage besides this coverage, *you* must tell the entity with which *you* enrolled.
15. Pay *your* monthly premium on time and pay all *deductible amounts, copayment amounts*, or *cost-sharing* percentages at the time of service.
16. Inform the entity in which *you* enrolled for this *policy* if *you* have any changes to *your* name, address, or family *members* covered under this *policy* within 60 days from the date of the event.

IMPORTANT INFORMATION

Provider Directory
A listing of *network providers* is available online at Ambetter.ARHealthWellness.com. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* healthcare services. You can find any of our *network providers* by visiting our website and selecting the "Find a Provider" function. There *you* will have the ability to narrow *your* search by *provider* specialty, zip code, gender, 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, specialty, and board certifications.

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

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

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

The ID card will show *your* name, *member* ID# and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-877-617-0390. *We* will send *you* another card.

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

1. Finding a *network provider*.
2. 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.
7. Current events and news.
8. *Our* formulary or preferred drug list.
9. *Deductible* and *Copayment* Accumulators.
10. Selecting a *primary care provider*.

Quality Improvement

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

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

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

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

DEFINITIONS

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

Wherever used in this *policy*:

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

Acute rehabilitation is rehabilitation for patients who will benefit from an intensive, multidisciplinary rehabilitation program. Patients normally receive a combination of therapies such as physical, occupational and speech therapy as needed and are medically managed by specially trained physicians. Rehabilitation services must be performed for three or more hours per day, five (5) to seven (7) days per week, while the *covered person* is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *skilled nursing facility*.

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

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

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

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

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

Ambulatory review means *utilization review* of healthcare services performed or provided in an outpatient setting.

Appeal means a request by the member or their representative to reverse, rescind, or otherwise modify an Adverse Benefit Determination.

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

Applied Behavioral Analysis (ABA) is the design, implementation, and evaluation of environmental modifications by a board-certified behavior analyst using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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

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

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

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

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

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

Billed Amount is the amount a provider charges for a service.
Calendar Year is the period beginning on the initial *effective date* of this *policy* and ending December 31 of that year. For each following year it is the period from January 1 through December 31.

Care Management is a program in which a registered nurse or licensed mental health professional, known as a case manager, assists a *member* through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and healthcare benefits available to a *member*.

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

Claim involving urgent care means any claim for care or treatment with respect to the application of the time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,
2. In the opinion of a physician with knowledge of the claimant's condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment is the subject of the claim.

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

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

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

Complications of pregnancy means:

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

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

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

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

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

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

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

Covered expense or ***covered service*** means an expense or service that is:

1. Incurred while *your* or *your dependent's* insurance is in force under this *policy*;
2. Covered by a specific benefit provision of this *policy*; and
3. Not excluded anywhere in this *policy*.

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

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

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

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

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

Custodial care includes but is not limited to the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    You may be billed for the difference between the amount paid and the provider's charge.
    b. When a *covered expense* (excluding Transplant Benefits) is received from a *non-network provider* as approved or *authorized* by us that is not the result of an *emergency*, or because the service or supply is not of a type provided by any *network provider*, the *eligible expense* is the lesser of (1) the negotiated fee, if any, that has been mutually agreed upon by *us* and the *provider*; or (2) the amount reasonably accepted by the *provider* (not to exceed the *provider's* charge).
    c. Except as provided under (2)(a) and (2)(b) above, when a *covered expense* (excluding Transplant Benefits) is received from a *non-network provider*, the *eligible expense* is determined based on the lowest amount of the following:
        i. the negotiated fee that has been agreed upon by *us* and the *provider*;
        ii. 100% of the fee Medicare allows for the same or similar services provided in the same geographical area;

iii. the fee established by *us* by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by *us*;
iv. the fee charged by the *provider* for the services; or
v. a fee schedule that *we* develop.

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

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

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

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

Emergency services means the following:

1. A medical screening examination, as required by federal law, that is within the capability of the emergency department of a *hospital*, including ancillary services routinely available to the emergency department, to evaluate an *emergency* medical condition;
2. Such further medical examination and treatment that are required by federal law to *stabilize* an *emergency* medical condition and are within the capabilities of the staff and facilities available at the *hospital*, including any trauma and burn center of the *hospital*.

Enhanced Direct Enrollment (EDE) means 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 into *your* consumer dashboard at enroll.ambetterhealth.com.

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

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

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

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

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

Items (3) and (4) above do not apply to phase 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 *policy*.

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

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

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

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

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

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

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

Habilitative or ***Habilitation Services*** means services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition. These services may include physical, occupational and speech therapies, developmental services and *durable medical equipment* for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder.

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

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

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

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 healthcare agency* and supervised by a registered nurse, which are directed toward the personal care of a *covered person.*

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

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

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

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

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

Hospital means an institution that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medical care means the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body and for transportation primarily for and essential to the provision of such care.

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

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

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

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

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

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

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

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

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

Necessary medical supplies mean medical supplies that are:

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

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

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

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

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

Neurologic Rehabilitation Facility means an institution licensed as such by the appropriate state agency. A neurological *rehabilitation* facility must:

1. be operated pursuant to law;
2. be accredited by the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities;
3. be primarily engaged in providing, in addition to room and board accommodations, *rehabilitation* services for *severe traumatic brain injury* under the supervision of a duly licensed *physician*; and
4. maintain a daily progress record for each patient.

Non-elective caesarean section means:

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

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

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

Other plan means any plan or *policy* that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, automobile no-fault or medical pay, homeowner insurance medical pay, premises medical pay, nonprofit

health service plans, health maintenance organization subscriber contracts, self-insured group plans, prepayment plans, and Medicare when the *covered person* is enrolled in Medicare. *Other plan* will not include Medicaid.

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

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

Period of extended loss means a period of consecutive days:

1. Beginning with the first day on which a *covered person* is a *hospital inpatient;* and
2. Ending with the 30th consecutive day for which a *covered person* is not a *hospital inpatient.*

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

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

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

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

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

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

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

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

Prior authorization means a decision to approve specialty or other *medically necessary* care for a *member* by the *member's* PCP or *provider* group prior to 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 claims and *network* re-pricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.

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

Provider facility means a *hospital, rehabilitation facility*, or *skilled nursing facility*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Schedule of Benefits means a summary of the *deductible*, *copayment*, *coinsurance*, *maximum out-of-pocket* and other limits that apply when *you* receive *covered services and supplies*.

Service area means a geographical area, made up of counties, where we have been *authorized* by the State of Arkansas to sell and market our health plans. This is where the majority of our *network providers* are located where you will receive all of your health care services and supplies.

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

Skilled nursing facility means an institution, or a distinct part of an institution, that:

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

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

Social determinants of health **are the circumstances in which people are born, grow up, live, work, and age. This also includes the systems in place to offer health care and services to a community.**
Specialist provider means a *physician* who focuses on a specific area of medicine and has additional expertise to help treat specific disorders or illnesses. Specialists may be needed to diagnose, manage, or treat certain types of symptoms and conditions related to their specific field of expertise.

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

Stabilize, as used when referring to an *emergency*, means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of an individual's medical condition is likely to result from or occur during a *transfer*, if the medical condition could result in any of the following:

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

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

Sub-acute rehabilitation means one or more different types of therapy provided by one or more *rehabilitation licensed practitioners* and performed for one-half (1/2) hour to two (2) hours per day, five (5) to seven (7) days per week, while the *covered person* is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *skilled nursing facility*.

Substance use or ***substance use disorder*** means alcohol, drug or chemical abuse, overuse, or dependency. Covered *substance use disorders* are those listed in the most recent editions of the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases.

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

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

***Surrogacy* Arrangement** means an understanding in which a woman (the *surrogate*) agrees to become pregnant and carry a child (or children) for another person (or persons) who intend to raise the child (or children), whether or not the *surrogate* receives payment for acting as a *surrogate*.

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

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

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

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

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

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

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

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

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

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

DEPENDENT MEMBER COVERAGE

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

1. The date *you* became covered under this *policy;* or
2. The date of marriage to add a *spouse*; or
3. The date of an eligible 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 *dependents* included in the application for this *policy* will be covered on *your effective date*.

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

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

Coverage for an Adopted Child
An adopted child of a *covered person* shall be covered from the date of the filing of a petition for adoption if (1) the *covered person* applies for coverage within sixty (60) days after the filing of the petition for adoption and where the issuer is notified by the Marketplace and (2) premium billed for this 60-day period is timely paid under the terms of this *policy* and its grace period after such application. However, the coverage shall begin from the moment of birth if (1) the petition for adoption and application for coverage is filed within sixty (60) days after the birth of the child, and (2) premium billed for this 60-day period is timely paid under the terms of this *policy* and its grace period after such application. The child will be covered for *loss* due to *injury* and *illness*, including *medically necessary* care and treatment of conditions existing prior to the date of *placement.*

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

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

1. The date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption; or
2. The date of entry of an order granting *you* or *your spouse* custody of the child for the purpose of adoption.

Adding Other Dependent Members
If *you* are enrolled in an off-exchange policy and apply in writing to add a *dependent* and *you* pay the required premiums, we will send you written confirmation of the added *dependent's effective date* of coverage and ID cards for the added *dependent.*

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

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

ONGOING ELIGIBILITY

For All Covered Persons
A *covered person's* eligibility for insurance under this *policy* will cease on the earlier of:

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

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

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

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

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

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

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

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

Open Enrollment
There will be an open enrollment period for coverage on the 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 Enrollment
A q*ualified individual* has sixty (60) days to report a qualifying event to the 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 q*ualified individual* or *dependent loses minimum essential coverage*, non-calendar year group or individual health insurance coverage, pregnancy-related coverage, access to healthcare services through coverage provided to a pregnant member's unborn child, or medically needed coverage;
2. A *qualified individual* gains a *dependent* or becomes a *dependent* through marriage, birth, adoption or placement for adoption, placement in foster care, or a child support order or other court order;
    a. In the case of marriage, at least one spouse must demonstrate having minimum essential coverage as described in 26 CFR 1.5000A-1b 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 Marketplace or HHS, or its instrumentalities as evaluated and determined by the Marketplace. In such cases, the Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or agent;
    - An enrollee adequately demonstrates to the Marketplace that the *qualified health plan* in which the *covered person* is enrolled substantially violated a material provision of its contract in relation to the enrollee's decision to purchase the qualified health plan based on plan benefits, service area or premium;
    - An *individual* is determined newly eligible or newly ineligible for *advance payments of the premium tax credit* or has a change in eligibility for *cost-sharing reductions*, regardless of whether such individual is already enrolled in a *qualified health plan*;
6. A *qualified individual* or enrollee gains access to new *qualified health plans* as a result of a permanent move;
7. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
    a. The qualifying events for employees are:
        i. Voluntary or involuntary termination of employment for reasons other than gross misconduct; or
        ii. Reduction in the number of hours of employment.
    b. The qualifying events for spouses are:
        i. Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct;
        ii. Reduction in the hours worked by the covered employee;
        iii. Covered employee's becoming entitled to Medicare;
        iv. Divorce or legal separation of the covered employee; or
        v. Death of the covered employee.
    c. The qualifying events for dependent children are the same as for the spouse with one addition:
        i. Loss of dependent child status under the plan rules.

    Note: The employee would not qualify for a special enrollment period if any of the criteria above has not been met.
    - An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a *qualified health plan* or change from one *qualified health plan* to another one time per month;
    - A *qualified individual* or enrollee demonstrates to the Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Marketplace may provide;

- A qualified individual or dependent is a victim of domestic abuse or spousal abandonment and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
- A qualified individual or dependent is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 days after the qualifying event;
- At the option of the Health Insurance Marketplace, a qualified individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a qualified health plan through the Health Insurance Marketplace following termination of Marketplace enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence;
- A *qualified individual* newly gains access to an employer sponsored individual coverage HRA or a Qualified Small Employer Health Reimbursement Arrangement (HRA).

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

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

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

PREMIUMS

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

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

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

When a *member* is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due before the first day of each month for coverage effective during such month. After the first premium is paid, a 60 day grace period starting from the premium due date is given for the payment of premium. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. Coverage will remain in force during the grace period; however, claims may pend for *covered services* rendered to the *member* during the grace period. *We* will notify HHS, as necessary, of the non-payment of premiums, the *member*, as well as *providers* of the possibility of denied claims when the *member* is in the grace period.

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

1. Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
2. Indian tribes, tribal organizations or urban Indian organizations;
3. State and Federal Government programs;
4. Family members; or
5. Private, not-for-profit foundations which have no incentive for financial gain, no financial relationship, or affiliation with providers of *covered services* and supplies on behalf of members, where eligibility is determined based on defined criteria without regard to health status and where

payments are made in advance for a coverage period from the *effective date* of eligibility through the remainder of the calendar year.

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

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

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

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

Misstatement of Tobacco Use
The *covered person's* answer to the tobacco question listed on the *covered person's* application for coverage is material to *our* determination of premium. If a *covered person's use of tobacco* has been misstated on the *covered person's* application for coverage under this *policy, we* have the right to charge corrected premiums for the *policy* back to the original *effective date*.

COST SHARING FEATURES

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

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

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

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

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

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

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

Note: The bill *you* receive for services or supplies from a *non-network provider* may be significantly higher than the *eligible expenses* for those services or supplies. In addition to the *deductible amount*, *copayment amount*, and *coinsurance* percentage, *you* are responsible for the difference between the *eligible expense* and the amount the *non-network provider* bills *you* for the services or supplies. Any amount *you* are

obligated to pay to the *non-network provider* in excess of the *eligible expense* will not apply to *your deductible amount* or *maximum out-of-pocket*.

ACCESS TO CARE

Primary Care Provider
In order to obtain benefits, you must designate a *network 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 *network 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. *You* may obtain a list of *network primary care providers* at *our* website and using the "find a Provider" function or by calling the telephone number shown on the front page of this *policy.*

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 directives 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 network primary care provider* for any reason, but not more frequently than once a month, by submitting a written request, online at *our* website at Ambetter.ARHealthWellness.com, or by contacting *our* office at the number shown on *your* identification card. The change to *your network primary care provider* of record will be effective no later than 30 days from the date *we* receive *your* request.

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 appointment, call 24 hours in advance. At every appointment, make sure *you* bring *your member* ID 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 1-877-617-0390 (TDD/TTY 1-877-617-0392). 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.

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

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

Non-Emergency Services Outside of Service Area
If you are traveling outside of the Arkansas 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 Arkansas 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. Except for Emergency health services or services for Dependent Enrollees residing outside the Service Area, if an Enrollee wishes to receive Benefits for Covered Services from an Out-of-Area Provider, then the Enrollee must ensure that the Out-of-Area Provider requests pre-authorization for the services or supplies. We will apply our Medical Coverage Policies when evaluating the Medical Necessity for the Out-of-Area Provider services, which includes considering the absence of or the exhaustion of all network resources. Failure to request pre-authorization will result in denial of coverage. Pre-authorization does not guarantee payment or assure coverage; all Claims for Benefits delivered by an Out-of-Area Provider must still meet all other terms, conditions, exclusions, and limitations of coverage.

If *you* are temporarily out of the service area and have a medical or behavioral health emergency, call 911 or go to the nearest emergency room. Be sure to 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.

MAJOR MEDICAL EXPENSE BENEFITS

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

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

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

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

Benefits for air ambulance services are limited to:

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

Exclusions:
No benefits will be paid for:

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

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

Chiropractic Services
Chiropractic services are covered when a chiropractor finds services are *medically necessary* to treat or diagnose neuromusculoskeletal disorders on an outpatient basis. Covered service expenses are subject to all other terms and conditions of the *policy*, including *deductible amount* and *cost sharing percentage* provisions.

Craniofacial Corrective Surgery and Related Expenses
Covered expenses shall include *craniofacial corrective surgery* and related *medical care* for a person of any age who is diagnosed as having a *craniofacial anomaly*, provided that the *surgery* and treatment are *medically necessary* to improve a functional impairment that results from the *craniofacial anomaly* as determined by the American Cleft Palate-Craniofacial Association in Chapel Hill, North Carolina. .

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

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

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

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

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

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

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

equipment. Rental costs must not be more than the purchase price. The plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are *covered services*. Payment for related supplies is a *covered service* only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the *member*; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered services may include, but are not limited to:

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

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

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

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

Covered services may include, but are not limited to:

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

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

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

Prosthetics

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

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

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

Covered services may include, but are not limited to:

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

Exclusions:

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

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

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

Covered *orthotic devices* may include, but are not limited to, the following:
1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.

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

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

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

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

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

Contraception
All FDA-approved contraception methods (identified on www.fda.gov) are approved for *members* without *cost sharing* as required under the Affordable Care Act. *Members* have access to the methods available and outlined on our Drug Formulary or Preferred Drug List without cost share. Some contraception methods

are available through a *member's* medical benefit, including the insertion and removal of the contraceptive device at no cost share to the *member*. This benefit contains both pharmaceutical and medical methods, including:

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

Diabetes Care

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

Dialysis Services

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

Covered expenses include:

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

After *you* receive appropriate training at a dialysis facility *we* designate, *we* cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis. Coverage is limited to the standard item of equipment or supplies that adequately meets *your* medical needs. *W*e will determine if equipment is made available on a rental or purchase basis. At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a *provider we* authorize before the purchase.

High Frequency Chest Wall Oscillators

Covered expenses for a *member* with cystic fibrosis, is provided for one high frequency chest wall oscillator during such *member's* lifetime.

Inotropic Agents for Congestive Heart Failure

Covered expenses for infusion of inotropic agents where the *member* is on a cardiac transplant list at a *hospital* where there is an ongoing cardiac transplantation program.

Mental Health and Substance Use Disorder Benefits

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

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

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

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 or *substance use disorder* services are as follows:

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

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

13. *Transcranial Magnetic Stimulation (TMS); and*
14. Assertive Community Treatment (ACT)

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

We oversee the delivery and oversight of covered behavioral health and *substance use disorder* services for Ambetter from Arkansas Health & Wellness. 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 Ambetter.ARHealthWellness.com or by calling Member Services at 1-877-617-0390 (TDD/TTY line 1-877-617-0392). *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 services benefits.

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

In addition, Integrated Care Management is available for all of *your* healthcare needs, including behavioral health and substance use. Please call 1-877-617-0390 (TDD/TTY line 1-877-617-0392) to be referred to a care manager for an assessment.

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.

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

Rehabilitation Expense Benefits
Covered expenses include expenses incurred for *rehabilitation* services, subject to the following limitations:

1. *Covered expenses* available to a *covered person* while confined primarily to receive *rehabilitation* are limited to those specified in this provision;
2. *Rehabilitation* services or confinement in a *rehabilitation facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay;
3. *Covered expenses* for *provider facility* services are limited to charges made by a *hospital* or *rehabilitation facility* for:
    a. Daily room and board and nursing services;
    b. Diagnostic testing; and
    c. Drugs and medicines that are prescribed by a *physician*, filled by a licensed pharmacist and approved by the U.S. Food and Drug Administration; and
4. *Covered expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners;*
5. Outpatient physical therapy, occupational therapy, speech therapy and aural therapy for rehabilitative purposes;
6. *Inpatient* physical therapy, occupational therapy, speech therapy and aural therapy for rehabilitative purposes; and
7. Cardiac *rehabilitation*, limited to 36 visits per *member* per year.

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

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

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

Neurological Rehabilitation Facility Services
Covered expenses for *neurologic rehabilitation facility* services are limited to:

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

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

1. *Custodial care* is not covered; and
2. Coverage is provided for a maximum of 60 days per *member* per lifetime.

Skilled Nursing Facility Expense Benefits
Covered expenses include expenses incurred for services or confinement in a *skilled nursing facility*, subject to the following limitations:

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

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

Habilitation Expense Benefits
Covered expenses include expenses incurred for *habilitation services*, subject to the following limitations:

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

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

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

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

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

to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase; and
7. Sleep studies.

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

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

Limitations:
Covered expenses for *home health aide services* will be limited to:
1. Seven visits per week; and
2. A *calendar year* maximum of fifty (50) visits.

Each eight-hour period of *home health aide services* will be counted as one visit.

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

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

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

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

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

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).

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

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

1. Daily room and board.
    a. *Hospital* admissions are subject to pre-admission notification. Please call the number listed on *your* identification card to notify *us* of the admission.
    b. Services rendered in a *hospital* in a country outside of the United States of America shall not be paid except at *our* sole discretion;
    c. Admissions to a long term acute care *hospital* or to a long term acute care division of a *hospital* are subject to pre-admission notification.
2. Daily room and board and nursing services while confined in an *intensive care unit*.
3. *Inpatient* use of an operating, treatment, or recovery room;
4. Outpatient use of an operating, treatment, or recovery room for *surgery;*
5. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients;*
6. For a condition requiring that *you* be isolated from other patients, *we* will pay for an isolation unit equipped and staffed as such; *and*
7. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. When *emergency* treatment is needed the *covered person* should seek care at the nearest facility. *Emergency* treatment received within forty-eight (48) hours of the *emergency* is subject to the *deductible*, *copayment* and *coinsurance* specified in the *Schedule of Benefits*. If the *covered person* is admitted as an *inpatient* to the same *hospital* where *emergency* treatment was rendered, the *emergency* treatment *copayment* is waived and all services are subject to the *inpatient* deductible, *copayment* and *coinsurance*.
    a. **After-Hours Clinic or Urgent Care Center.** Services provided in an after-hours *urgent care center* are subject to the *urgent care* deductible, *copayment* and *coinsurance* for each visit.
    b. **Observation Services.** Observation services are covered when ordered by a *physician*.
    c. **Transfer to Network Hospital.** Continuing or follow-up treatment for *injury* or *emergency* treatment is limited to care that meets primary coverage criteria before you can be safely *transferred*, without medically harmful or injurious consequences, to a *network hospital* in the *service area*. Services are subject to all applicable deductible, *copayment* and *coinsurance*.
    d. **Emergency Hospital Admissions.** *You* are responsible for notifying Ambetter from Arkansas Health & Wellness of an *emergency* admission to a *hospital* within 24 hours or the next business day. Failure to notify Ambetter from Arkansas Health & Wellness may result in the *covered person* paying a greater portion of the medical bill.
    e. **Medical Review of Emergency Care.** *Emergency* treatment is subject to medical review. If, based upon the signs and symptoms presented at the time of treatment as documented by

attending healthcare personnel, Ambetter from Arkansas Health & Wellness determines that a visit to the emergency room fails to meet the definition of *emergency* treatment, coverage shall be denied and the emergency room charges will become the *covered person's* responsibility.

8. Services of a social worker while hospitalized.

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.

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

Medical and Surgical Expense Benefits
Medical *covered expenses* are limited to charges:

1. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies;
2. Made by an assistant surgeon;
3. Services of standby *physicians* are only covered in the event such *physician* is required to assist with certain high-risk services specified by Ambetter from Arkansas Health & Wellness, and only for such time as such *physician* is in immediate proximity to the patient;
4. For the professional services of a *medical practitioner*, including *surgery;*
5. For electronic consultations between a *medical practitioner*, with other involved *medical practitioners*. Benefits include telephone calls or other forms of electronic consultations between a *medical practitioner* and a *covered person*, or between a *medical practitioner* and another *medical practitioner;*
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies;*
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services. This includes advanced diagnostic imaging such as computed tomography scanning (CT SCAN‖), Magnetic Resonance Angiography or Imaging (MRI/MRA‖), Nuclear Cardiology and positron emission tomography scans (PET SCAN‖) referred to as —advanced diagnostic imaging. This will require *prior authorization* from *us*;
8. For chemotherapy and radiation therapy or treatment on an *inpatient* or outpatient basis;
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components;
10. For the cost and administration of an anesthetic;
11. For oxygen and its administration;
12. For *dental expenses* when a *covered person* suffers an *injury,* after the *covered person's effective date* of coverage, that results in:
    a. Damage to the *member's* natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any *injury* as a result of chewing;

13. For reconstructive breast *surgery* charges as a result of a partial or total mastectomy. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas;
14. Testing of newborn children, including testing for Down's syndrome, hypothyroidism, sickle-cell anemia, phenylketonuria/galactosemia, PKU and other disorders of metabolism, and spinal muscular dystrophy. Testing for spinal muscular dystrophy will not be subject to a deductible or copayment;
15. For the following types of tissue transplants:
    a. Cornea transplants;
    b. Artery or vein grafts;
    c. Heart valve grafts;
    d. Prosthetic tissue replacement, including joint replacements; and
    e. Implantable prosthetic lenses, in connection with cataracts;
16. Coverage for anesthesia and *hospital* or ambulatory surgical facility charges for services performed in connection with dental procedures in a *hospital* or ambulatory surgical facility, if the *provider* certifies that because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures; and the patient is a child under seven (7) years of age who is determined by (2) licensed dentists to require dental treatment in a *hospital* or ambulatory surgical center for a significantly complex dental condition; a person with a diagnosed serious mental or physical condition; or a person with a significant behavioral problem;
17. Coverage for *gastric pacemakers* for *covered persons* diagnosed with *gastroparesis*, eligible charges and limits are based on *medical necessity* and require *prior authorization*;
18. Infertility counseling and planning services when provided by a *network provider*, and testing to diagnose infertility;
19. Cochlear implants;
20. Hearing Aids- limited to one pair each three year period;
21. One auditory brain stem implant per lifetime for an individual twelve years of age and older with a diagnosis of Neurofibromatosis Type II (NF2) who has undergone or is undergoing removal of bilateral acoustic tumors;
22. Implantable osseointegrated hearing aid for patients with single-sided deafness and normal hearing in the other ear. Coverage is further limited to *members* with:
    a. congenital or surgically induced malformations (e.g. atresia) of the external ear canal or middle ear;
    b. chronic external otitis or otitis media, subject to Prior Approval;
    c. tumors of the external canal or tympanic cavity; and
    d. sudden, permanent, unilateral hearing *loss* due to trauma, idiopathic sudden hearing *loss*, or auditory nerve tumor;
23. Testing and evaluation limited to fifteen (15) hours per *member* per year:
    a. Psychological testing, including but not limited to, assessment of personality, emotionality and intellectual abilities;
    b. For children under the age of six (6), childhood developmental testing, including but not limited to assessment of motor, language, social, adaptive or cognitive function by standardized developmental instruments;
    c. Neurobehavioral status examination, including, but not limited to assessment of thinking, reasoning and judgment;
    d. Neuropsychological testing, including, but not limited to Halstead-Reitan, Luria and WAIS-R.
24. *Medically necessary services* made by a *physician* in an *urgent care center*, including facility costs and supplies;

25. New Intervention (one that is not commonly recognized as a *generally accepted standard of medical practice*) when it is shown through scientific evidence that the intervention will achieve its intended purpose and will prevent, cure, alleviate or enable diagnosis or detection of a medical condition without exposing the *member* to risks that outweigh the potential benefits. New interventions in the process of phase I, II or III trials are not covered;
26. Nutritional and Dietary counseling services for *members* in connection with cleft palate management and for nutritional assessment programs provided in and by a *hospital*;
27. Allergy testing;
28. For *medically necessary* genetic blood tests;
29. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV);
30. *Telehealth*; and
31. Oral surgery (non-dental related only) is covered for:
    a. Tumors/cysts (excision when attached to the jaws, cheeks, lips, tongue, roof or floor of mouth when a pathological exam is required);
    b. Exostoses (excision of jaws and hard palate);
    c. Celluitis (external incision and a drainage); and
    d. Sinuses, salivary glands or ducts (incision of accessory sinuses, salivary glands or ducts).

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

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

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

covered person following a covered cataract *surgery*. See the *Schedule of Benefits* for benefit levels or additional limits; and

6. For the cost of a monofocal lens, if the multifocal lens is implanted after a cataract extraction.

Prescription Drug Expense Benefits

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

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

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

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

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

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

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

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

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

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

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

23. For any injectable medication or biological product that is not expected to be self-administered by the *member* at the *member's* place of residence unless listed on the formulary.

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
Prescriptions 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 Ambetter.ARHealthWellness.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 Ambetter.ARHealthWellness.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, 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 option, 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.

For the most current Ambetter Formulary or Prescription Drug List or for more information about our pharmacy program visit Ambetter.ARHealthWellness.com (under "for Member", "Pharmacy Resources") or call Member Services at 1-877-617-0390 (TDD/TTY line 1-877-617-0392).

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

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

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

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

External exception request review
If *we* deny a request for a standard exception or for an expedited exception, the *member*, the *member's* designee or the *member's* prescribing *physician* may request that the original exception request and subsequent denial of such request be reviewed by an *independent review organization*. *We* will make our determination on the external exception request and notify the *member*, the *member's* designee or the *member's* prescribing *physician* of *our* coverage determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception.

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

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

1. Routine ophthalmological exam
    a. Refraction;
    b. Dilation;
    c. Contact lens fitting.
2. Frames
3. Prescription lenses

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

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

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

Non-network care without *prior authorization*

Other Dental Services

Anesthesia and *hospital* charges for dental care, for a *member* less than 19 years of age or a *member* who is physically or mentally disabled, are covered if the *member* requires dental treatment to be given in a *hospital* or outpatient ambulatory surgical facility. The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Preventive Care Expense Benefits

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

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual;
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration;
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women;
5. Complications resulting from the smallpox vaccine;
6. BRCA genetic cancer testing for women with a family history of certain cancers; and
7. Covers without *cost sharing*:
    a. Screening for *tobacco use*; and
    b. For those who *use tobacco* products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
        i. Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without *prior authorization*; and
        ii. All Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a *healthcare provider* without *prior authorization*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Social Determinants of Health Supplemental Benefits
Social determinants of health supplemental benefits and services may be offered to members to remove barriers to accessing health services and improve overall health outcomes. These are benefits and services that we may make available in connection with this contract. The benefits and services provided may include transportation to health services, assistance with childcare, access to healthy meals, and other relevant services based on need. The benefits are available as long as coverage remains active, unless changed by us. Upon termination of coverage, the benefits are no longer available. All members are automatically eligible for the benefits upon obtaining coverage. The services are optional, and the benefits are made available at no additional cost to the enrollees. The benefits and services available at any given

time are made part of this contract by this reference and are subject to change by us through an update to information available on our website or by contacting us.

Social determinants of health benefits and services may be offered to enrollees through the "My Health Pays" wellness program and through local health plan websites. Members may receive notifications about available benefits and services through emails from local health plans and through the "My Health Pays" notification system. To inquire about these benefits and services or other benefits available, you may visit our website at Ambetter.ARHealthWellness.com or by contacting Member Services at 1-877-617-0390 (TDD/TTY 1-877-617-0392).

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

Transplant Services
Covered expenses for transplant service expenses:

Transplants are a covered benefit when a member is accepted as a transplant candidate and pre-*authorized* in accordance with this *policy*. *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 policy 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 *policy* 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 a *covered person and donor* are appropriate candidates for a *medically necessary* transplant, live donation, *covered service expenses* will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting.
3. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant);
4. 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 *covered person* 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 a participating facility;

7. Post-transplant follow-up visits and treatments;
8. Donor testing if the donor is found compatible;
9. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors; and
10. 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 *covered person's policy*, after benefits for the *covered person'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 *covered person's policy.*

Ancillary "Center Of Excellence" Service Benefits:
A *covered person* may obtain services in connection with a *medically necessary* 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 *covered person* 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 service for the following services:
    a. Transportation for the *covered person,* any live donor, and the *immediate family* to accompany the *covered person* to and from the *Center of Excellence*, in the United States.
    b. When *covered person* 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 *covered person* while the *covered person* is confined in the *Center of Excellence* in the United States*. We* will reimburse members for the proof of costs directly related for transportation, lodging, and any of the following approved items listed in the member transplant reimbursement 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 *covered person* 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 *medically necessary* transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision 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 through the Center of Excellence and is not included under this provision as a transplant.
7. The acquisition cost for the organ or bone marrow, when provided at an un*authorized* facility or not obtained through the Center of Excellence.
8. For any transplant services and/or travel related expenses for the enrollee and donor, when performed outside of the United States.
9. 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, hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.)
    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, etc.
    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 pre-check, 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 *policy'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 *policy'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.

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

Wellness and Other Program Benefits
Benefits may be available to enrollees for participating in certain programs that we may make available in connection with this contract. Such programs may include wellness programs, disease or *care management* programs, and other programs as found under the Health Management Programs Offered provision. 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 Ambetter.ARHealthWellness.com or by contacting Customer Service by telephone at 1-877-617-0390 (TDD/TTY 1-877-617-0392). The benefits are available as long as coverage remains active, unless changed by us as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All enrollees are automatically eligible for program benefits upon obtaining coverage. The programs are optional, and the benefits are made available at no additional cost to the enrollees. The programs and benefits available at any given time are made part of this contract by this reference and are subject to change by us through updates available on our website or by contacting us.

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 1-877-617-0390 (TDD/TTY line 1-877-617-0392).

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

- The *investigational* item or service itself;

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

Clinical trials must meet the following requirements:

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

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

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

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

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

Second Medical Opinion

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

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

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

PRIOR AUTHORIZATION

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 medical and behavioral health *covered expenses* require *prior authorization*. In general, *network providers* must obtain *authorization* from *us* prior to providing a service or supply to a *covered person.* However, there are some *network eligible expenses* for which *you* must obtain the *prior authorization*.

For services or supplies that require *prior authorization*, as shown on the *Schedule of Benefits*, *you* must obtain *authorization* from *us* before *you* or *your dependent member:*

1. Receives a service or supply*;* or
2. Are admitted into a facility*.*

Prior Authorization (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 an inpatient admission, including emergent inpatient admission.
5. At least 5 days prior to the start of *home healthcare* except *members* needing *home health care* after *hospital* discharge.

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

1. For immediate request situations, within 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 1 business day of receipt of all information, but no later than 72 hours from date of receipt of request.
4. For non-urgent pre-service reviews, within 2 business days of receipt of all information, but no later 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 *covered person.*

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

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

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

Prior Authorization Does Not Guarantee Benefits
Our authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *policy.*

Denial of Prior Authorization
Refer to the Appeal, Grievance and External Review Procedures section of this policy for information on your right to appeal a denied authorization.

Requests for Predeterminations
You may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

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

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

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

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

GENERAL LIMITATIONS AND EXCLUSIONS

No benefits will be paid for:

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

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

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

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

d. Testing of aptitude, ability, intelligence or interest; and
e. Evaluation for the purpose of maintaining employment. Benefits will be allowed for services that would otherwise be covered under this policy.

14. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Expense Benefits;
15. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism;
16. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services, unless expressly provided for by the *policy*;
17. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*;
18. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs;
19. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the *policy*;
20. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition;
21. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of ninety (90) consecutive days;
22. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *covered person* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *covered person's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *covered person's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency;
23. Surrogacy Arrangement. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a *member*, and any child born as a result of a *surrogacy arrangement*. This exclusion applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the *surrogate* following childbirth);
    d. Mental health services related to the *surrogacy arrangement*.
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
    h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement*;
    i. Any complications of the child or surrogate resulting from the pregnancy; or
    j. Any other health care services, supplies and medication relating to a surrogacy arrangement.
    k. Any and all health care services, supplies or medication provided to any child birthed by a surrogate as a result of a surrogacy arrangement are also excluded, except where the child is the adoptive child of insureds possessing an active policy with us and/ or the child possesses an active policy with us at the time of birth.
24. For or related to treatment of hyperhidrosis (excessive sweating);
25. For fetal reduction *surgery*;

26. Except as specifically identified as a *covered expense* under the *policy*, expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health;
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 *covered person* is paid to participate or to instruct; racing or speed testing any non-motorized vehicle or conveyance, if the *covered person* is paid to participate or to instruct; rodeo sports; horseback riding, if the *covered person* is paid to participate or to instruct; rock or mountain climbing, if the *covered person* is paid to participate or to instruct; or skiing, if the *covered person* is paid to participate or to instruct;
28. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *covered person* is a pilot, officer, or *member* of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft;
29. For *prescription drugs* for any *covered person* who enrolls in Medicare Part D as of the date of the *covered person's* enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date;
30. For the following miscellaneous items: artificial insemination except where required by federal or state law; biofeedback; care or complications resulting from non-*covered expenses*; chelating agents; domiciliary care; food and food supplements; routine foot care, foot orthotics, corrective shoes, or orthopedic shoes that are not attached to an appliance; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; private duty nursing; *rehabilitation* services for the enhancement of job, athletic or recreational performance; routine or elective care outside the *service area*; sclerotherapy for varicose veins; treatment of spider veins; transportation expenses; unless specifically described in this *policy*;
31. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment. Benefits will be allowed for services that would otherwise be covered under this policy;
32. Take-home dressings and supplies following hospitalization; any other supplies, dressings, appliances, devices or services which are not specifically listed as covered above**;** replacement or repair of appliances, devices and supplies due to *loss*, breakage from willful damage, neglect or wrongful use, or due to personal preference;
33. Services or supplies eligible for payment under either federal or state programs (except Medicaid). This exclusion applies whether or not *you* assert *your* rights to obtain this coverage or payment of these services;
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. With the exception of certain services to diagnose infertility, which are limited as set forth in this *policy*, *we* will not cover any diagnosis, treatments, surgeries, procedures, medications, or any other services related to infertility; and
36. For any medicinal and recreational use of cannabis or marijuana.

OUT-OF-AREA PROVIDERS: Except for Dependent Enrollees living outside the Service Area, Enrollees travelling outside of the Service Area will be responsible for ensuring that their Out-of-Area Providers obtain pre-authorization to be eligible for Benefits for any non-Emergency health services, including admissions to Out-of-Area Facilities. We apply our Medical Coverage Policies to all requests when evaluating the Medical Necessity for the Out-of-Area Provider services, which includes considering the

absence of or the exhaustion of all network resources. Failure to request pre-authorization will result in denial of coverage.

TERMINATION

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

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

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

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

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

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

(2) When a *provider's* participation is terminated, the provider's patients under the plan may continue to receive care from that *provider* as an in-*network* benefit until a current episode of treatment for an acute condition is completed or until the end of ninety (90) days, whichever occurs first.

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

SUBROGATION AND RIGHT OF REIMBURSEMENT

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

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

If this plan provides benefits under this contract to a *covered person* for expenses incurred due to *third party injuries*, then the plan retains the right to repayment of the full cost of all benefits provided by this plan on behalf of the *covered person* that are associated with the *third party injuries*. The plan's rights of recovery apply to any recoveries made by or on behalf of the *covered person* from any source, including, but not limited to:

- Payments made by a *third party* or any insurance company on behalf of the *third party*;
- Any payments or awards under an uninsured or underinsured motorist coverage *policy*;
- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any automobile *policy*, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and
- Any other payments from a source intended to compensate a *covered person* for *third party injuries*.

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

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

As a condition for *our* payment, the *covered person* or anyone acting on the *covered person's* behalf including, but not limited to, the guardian, legal representatives, estate, or heirs agrees:

1. To fully cooperate with *us* in order to obtain information about the *loss* and its cause;
2. To immediately inform *us* in writing of any claim made or lawsuit filed on behalf of a *covered person* in connection with the *loss*;
3. To include the amount of benefits paid by *us* on behalf of a *covered person* in any claim made against any *third party*;
4. To give Ambetter from Arkansas Health & Wellness a first-priority lien on any recovery, settlement or judgment or other sources of compensation which may be had from any party to the extent of the full cost of all benefits associated with *third party injuries* provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);

5. To pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due Ambetter from Arkansas Health & Wellness as reimbursement for the full cost of all benefits associated with *third party injuries* provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement);
6. That *we*:
    a. Will have a lien on all money received by a *covered person* in connection with the *loss* equal to the amount *we* have paid;
    b. May give notice of that lien to any *third party* or *third party's* agent or representative;
    c. Will have the right to intervene in any suit or legal action to protect *our* rights;
    d. Are subrogated to all of the rights of the *covered person* against any *third party* to the extent of the benefits paid on the *covered person's* behalf; and
    e. May assert that subrogation right independently of the *covered person*;
7. To take no action that prejudices *our* reimbursement and subrogation rights, including, but not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan;
8. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights;
9. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so;
10. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses; and
11. That *we* may reduce other benefits under the *policy* by the amounts a *covered person* has agreed to reimburse *us*.

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

COORDINATION OF BENEFITS

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

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

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

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

1. If a plan is advised by a *covered person* that all plans covering the person are high-*deductible* health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-*deductible* health plan's *deductible* is not an allowable expense, except for any health care expense incurred that may not be subject to the *deductible* as described in Section 223 (c)(2)(C) of the Internal Revenue Code of 1986.
2. An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.
3. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a *covered person* is not an allowable expense.

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

a) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense, unless one of the plans provides coverage for hospital room expenses.
b) If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.
c) If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated frees is not an allowable expense.
d) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefits or services for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

The term "Plan" includes:

1. Group and non-group insurance contracts and subscriber contracts;
2. Uninsured arrangements of group or group-type coverage;
3. Group and non-group coverage through closed panel plans;
4. Group-type contracts;
5. The medical Care components of long-term care contracts, such as skilled nursing care;
6. The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contract; and
7. Medicare or other governmental benefits, as permitted by law.

The term "Plan" does not include:

1. Hospital indemnity coverage benefits or other fixed indemnity coverage;
2. Accident only coverage;
3. Specified disease or specified accident coverage;
4. Limited benefit health coverage;
5. School accident-type coverages that cover students for accident only, including athletic injures, wither on a twenty-four hour basis or on a "to and from school" basis;
6. Benefits provided in long-term care insurance policies of non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and *custodial care* or for contracts that pay a fixed daily benefits without regard to expense incurred or the receipt of services;
7. Medicare supplement polices;
8. A state plan under Medicaid; or
9. A governmental plan, which by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

"Primary plan" is one whose benefits must be determined without taking the existence of any *other plan* into consideration. A plan is primary if either:

1. the plan has no order of benefits rules or its rules differ from those required by regulation; or
2. all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

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

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 1-7 that applies will determine which plan will be primary:

1. The Primary plan pays or provides its benefits as if the Secondary plan or plans did not exist. A Plan may consider benefits paid or provided by another Plan in determining its benefits only when it is secondary to that *other plan*.

2. If the *other plan* does not contain a coordination of benefits provision that is consistent with this provision, that plan is always primary. There are two exceptions:
    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, and

b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a *covered person* may continue to be excess to such basic benefits.

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

4. Active Employee or Retired or Laid-off Employee. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee,

the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored. This rule does not apply if the rule 3(a) can determine the order of benefits.

5. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 3(a) can determine the order of benefits.

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

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

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

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

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

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

CLAIMS

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

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

Proof of Loss
We must receive written *proof of loss* within one hundred eighty (180) days of the *loss* or as soon as is reasonably possible. *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-area 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 Ambetter.ARHealthWellness.com under "Member Resources". Send all the documentation to *us* at the following address:

Ambetter from Arkansas Health & Wellness
Attn.: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

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

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

promptly provide to *us*, or *our* representative, any information, records or documents requested by *us*.

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

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

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

We will pay or deny a clean claim within 30 days of receipt if the claim was submitted electronically or within 45 days after receipt if the claim was submitted by other means. We will pay 12% interest after the 61st day of nonpayment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPEAL, GRIEVANCE AND EXTERNAL REVIEW PROCEDURES

Overview

Your satisfaction is very important to us. We want to know your issues and concerns so we can improve our services. Reporting these will not affect your healthcare services. The following processes are available to address your concerns.

Call Member Services

Please contact our Member Services team at 1-877-617-0390 (TDD/TYY 1-877-617-0392) if you have questions or concerns. We will attempt to answer your questions during initial contact, as most concerns can be resolved with one phone call.

Appeal

An *appeal* means any request by the member or their representative to reverse, rescind, or otherwise modify an Adverse Benefit Determination. You can appeal these decisions. You can designate a representative – such as a family member, friend, physician, or attorney – to appeal these decisions on your behalf.

Filing an Appeal

When *we* make an *adverse benefit determination,* we will send you a notification that includes information to file an appeal and how to authorize a representative. You have 180 calendar days to file an appeal from the date we issue the *adverse benefit determination.*

You can file an appeal by filling out the form included with the denial notice, sending a letter, or by phone to:

Ambetter from Arkansas Health & Wellness
Attn: Appeals Unit
P.O. Box 25538, Little Rock, AR 72221
Fax: 1-866-811-3255
Phone: 1-877-617-0390 (TDD/TYY 1-877-617-0392)

Please include in *your* written appeal or be prepared to tell us the following:

1. Name, address and telephone number of the insured person;
2. The insured's health plan identification number;
3. Name of *healthcare provider*, address and telephone number;
4. Date the healthcare benefit was provided (if a post-claim denial appeal)
5. Name, address and telephone number of an *authorized representative* (if appeal is filed by a person other than the insured); and
6. A copy of the notice of *adverse benefit determination.*

Processing your Appeal

After you file your appeal, *we* will notify you in writing of all the information that is needed to process the appeal within 5 business days of receipt of the appeal. You will be informed that *you* can present any information that *you* wish for *us* to consider as part of the appeal. *We* will investigate the appeal to decide if more information is needed form *you* or *your* Provider.

A reviewer of the same or similar specialty will review the request and make a determination. This reviewer will not be the physician involved in the original decision and who is not the subordinate of that physician.

Ambetter from Arkansas Health and Wellness may extend our deadline by not more than 14 calendar days if *we* need additional information to reach a decision. *We* will inform you of the requests's status if such an extension is necessary. If *we* do not receive the required information within the extended timeframe, *we* will make a determination based on the information *we* have. If no extension is needed, *we* will make the decision within the following timeframes of receipt of your appeal:

- 72 hours after receiving *your* request when *you* are appealing the denial of a claim for urgent care. (If *your* appeal concerns urgent care, *you* may be able to have the internal appeal and external reviews take place at the same time.)
- 30 days for appeals of denials of non-urgent care *you* have not yet received.
- 60 days for appeals of denials of services *you* have already received (post-service denials)

We will notify you and your authorized representative in writing within two (2) business days of the decision.

The notice will include an explanation of *our* decision, a reference to the criteria on which the decision was based, a list of the title and qualification of each person participating in the review, and a description of *your* further appeal rights include the right to an External Review.

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

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

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

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

To assure *you* receive notice of our decision, we will contact *you* by telephone or facsimile (fax) or by another method meant to provide the decision to *you* quickly.

In determining whether a claim involves urgent care, the plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. **However, if a *physician* with knowledge of *your* medical condition determines that a claim involves urgent care, or an *emergency*, the claim must be treated as an urgent care claim.**

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

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

Defined terms: Any terms appearing in *italics* are defined.

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

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

***Your* Rights to a Full and fair review**. The plan must allow *you* to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.

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

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

3. The adverse determination must be written in a manner understood by *you*, or if applicable, *your authorized representative* and must include all of the following:

    a. The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);
    b. Information sufficient to identify the claim involved, including the date of service, the *healthcare provider*; and
    c. A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

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

Other Resources to help *you*

Department of Insurance: For questions about *your* rights or for assistance *you* may also contact the Consumer Services Division at The Arkansas Department of Insurance (800) 852-5494. *You* have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 271-2640 or write the Department at 1 Commerce Way, Suite 102, Little Rock, AR 72202.

Language services are available from the health benefit plan.

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

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

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

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

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

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

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

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

Concurrent urgent care and extension of treatment: Under the concurrent care provisions , any request that involves both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved by the plan must be decided as soon as possible, taking into account the medical urgencies, and notification must be provided to the claimant within 24 hours after receipt of the claim, provided the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Non-urgent request to extend course of treatment or number of treatments: If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the plan does not involve urgent care, the request may be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, e.g., as a *pre-service claim* or a *post-service claim*.
If the request is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request must be treated as a *claim involving urgent care* and decided in

accordance with the urgent care claim timeframes, e.g., as soon as possible, taking into account the medical emergencies, but not later than 72 hours after receipt.

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 from Arkansas Health & Wellness
Attn: Claims Disputes
PO Box 5000
Farmington, MO 63640-5000

EXTERNAL REVIEW

Right to External Review

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

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

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

***You* may file the request for an *external review* by contacting the Arkansas Insurance Department**
External Review Division, Arkansas Insurance Department at 1 Commerce Way, Suite 102, Little Rock, AR 72202 or via email to: insurance.Consumers@arkansas.gov. Information about external reviews is also available on the Department's website: http://insurance.arkansas.gov/csd.htm.

Non-urgent request for an external review

Unless the request is for an expedited external review, the plan will initiate an external review within 5 days after it receives *your* written request if *your* request is complete. The plan will provide *you* with notice that it has initiated the external review that includes:
(a) The name and contact information for the assigned *independent review organization* or the Insurance Commissioner, as applicable, for the purpose of submitting additional information; and
(b) Except for when an expedited request is made, a statement that *you* may, with 10 business days after the date of receipt of the notice, submit, in writing, additional information for either the *independent review organization* or the Insurance Commissioner to consider when conducting the external review.

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

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

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

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

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

To be eligible for an external review under this provision, *your* treating *provider* shall certify that one of the following situations is applicable:

1. Standard healthcare services have not been effective in improving *your* condition;
2. Standard healthcare services are not medically appropriate for *you*; or
3. There is no available standard healthcare service covered by the health plan issuer that is more beneficial than requested healthcare service.

If the request for an *expedited external review* is complete and eligible, the plan will immediately provide or transmit all necessary documents and information considered in making the *adverse benefit determination* in question to the assigned *independent review organization (IRO)* by telephone, facsimile or other available expeditious method.

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

Independent Review Organization: An *external review* is conducted by an *independent review organization (IRO)* selected on a random basis as determined in accordance with Arkansas law. The *IRO* will provide *you* with a written notice of its decision to either uphold or reverse the plan's *adverse benefit determination* within 45 days of receipt of a *standard external review (not urgent)*.

If an *expedited external review* (urgent) was requested, the *IRO* will provide a determination as soon as possible or within 72 hours of receipt of the expedited request. The *IRO's* decision is binding on the

company. If the *IRO* reverses the health benefit plan's decision, the plan will immediately provide coverage for the healthcare service or services in question.

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

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

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

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

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

Grievance

A grievance is a complaint about anything other than an Adverse Benefit Determination. Grievances may refer to any dissatisfaction about:

a. Us, as the insurer; e.g., customer service grievances – "the person to whom I spoke on the phone was rude to me";
b. Providers with whom we have a direct or indirect contract;
    a. Lack of availability and/or accessibility of network providers not tied to an unresolved benefit denial; and
    b. Quality of care/quality of service issues;
c. Expressions of dissatisfaction regarding quality of care/quality of service;

Filing a Grievance

You or your authorized representative may file a grievance by calling our Member Services Team at 1-877-617-0390 (TDD/TTY 1-877-617-0392) or in writing by mailing or faxing your grievance to:

Ambetter from Arkansas Health & Wellness,
Attn: Appeals Unit,
P.O. Box 25538, Little Rock, AR 72221
Fax: 1-866-811-3255

If filing a written grievance, please include:

- Your first and last name
- Your Member ID number
- Your address and telephone number
- Details surrounding your concern
- Any supporting documentation

Grievance Process and Resolution Timeframes

We will acknowledge your grievance by sending you a letter within five (5) business days of receipt of your grievance.

Grievances will be promptly investigated and will be resolved within 30 calendar days of receipt. We will notify you in writing within 2 business days of the decision. The time period may be extended for an additional 14 calendar days, making the maximum time for the entire grievance process 44 calendar days if we provide you or your authorized representative, if applicable, written notification of the following with the first 30 calendar days:

a. That we have not resolved the grievance;
b. When our resolution of the grievance may be expected; and
c. The reason why the additional time is needed

If we do not receive the required information before the end of the extension period we will resolve the grievance with the information we have on file.

Appeal and Grievance Filing and Key Communication Timelines

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard Grievance	N/A	5 Business Days	30 Calendar Days	14 Calendar Days
Standard Pre-Service Appeal	180 Calendar Days	5 Business 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 Business Days	60 Calendar Days	14 Calendar Days
External Review	120 Calendar Days	N/A	30 Calendar Days	N/A
Expedited External Review	120 Calendar Days	N/A	72 Hours	N/A

GENERAL PROVISIONS

Entire Contract
This *policy,* with the application, is the entire contract between *you* and *us.* No agent may:

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

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

Reinstatement
If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy provided; however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects, the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

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

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

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

Repayment for Fraud, Misrepresentation or False Information
If a *covered person* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *covered person* under this *policy* or in filing a claim for *policy* benefits, *we* have the right to demand that *covered person* pay back to *us* all benefits that *we* paid during the time *covered person* was insured under the *policy*. If it is determined that the *policy* should not have been issued or that benefits were paid due to fraud, misrepresentation or false information, premiums paid on behalf of the *covered person* will be returned, minus the total amount of all benefits paid on behalf of the *covered person.*

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

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://ambetter.arhealthwellness.com/privacy-practices.html or call Member Services at 1-877-617-0390 (TDD/TTY line 1-877-617-0392).

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://ambetter.arhealthwellness.com/language-assistance.html.

Conditions Prior To Legal Action
On occasion, *we* may have a disagreement related to coverage, benefits, premiums, or other provisions under this *policy*. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Arkansas Health & Wellness, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-617-0390 (TTY/TDD 1-877-617-0392).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Arkansas Health & Wellness, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-617-0390 (TTY/TDD 1-877-617-0392).
Marshallese:	Ñe kwe, ak bar juon eo kwōj jipañe, ewōr an kajitōk kōn Ambetter from Arkansas Health & Wellness, ewōr am jimwe in bōk jipañ im melele ko ilo kajin eo am ejjeļok wōṇāān. Ñan kōnono ippān juon ri-ukōk, kirļok 1-877-617-0390 (TTY/TDD 1-877-617-0392).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Arkansas Health & Wellness 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-877-617-0390 (TTY/TDD 1-877-617-0392)。
Laotian:	ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ ມີຄໍາຖາມກ່ຽວກັບ Ambetter from Arkansas Health & Wellness of Arkansas, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ ໃຫ້ໂທຫາ 1-877-617-0390 (TTY/TDD 1-877-617-0392).
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Arkansas Health & Wellness, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-617-0390 (TTY/TDD 1-877-617-0392).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Arkansas Health & Wellness، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-617-0390 (TTY/TDD 1-877-617-0392).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Arkansas Health & Wellness hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-617-0390 (TTY/TDD 1-877-617-0392) an.
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Arkansas Health & Wellness, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-877-617-0390 (TTY/TDD 1-877-617-0392).
Hmong:	Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Ambetter from Arkansas Health & Wellness, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-877-617-0390 (TTY/TDD 1-877-617-0392).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Arkansas Health & Wellness 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-617-0390 (TTY/TDD 1-877-617-0392) 로 전화하십시오.
Portuguese:	Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from Arkansas Health & Wellness, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-617-0390 (TTY/TDD 1-877-617-0392).
Japanese:	Ambetter from Arkansas Health & Wellness について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-877-617-0390 (TTY/TDD 1-877-617-0392) までお電話ください。
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from Arkansas Health & Wellness 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 1-877-617-0390 (TTY/TDD 1-877-617-0392) पर कॉल करें।
Gujarati:	જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter from Arkansas Health & Wellness વિશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-877-617-0390 (TTY/TDD 1-877-617-0392) ઉપર કૉલ કરો.

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Statement of Non-Discrimination

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

Ambetter from Arkansas Health & Wellness:

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

If you need these services, contact Ambetter from Arkansas Health & Wellness at 1-877-617-0390 (TTY/TDD 1-877-617-0392).

If you believe that Ambetter from Arkansas Health & Wellness has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a *grievance* with: Ambetter from Arkansas Health & Wellness Appeals Unit, P.O. Box 25538, Little Rock, AR 72221, 1-877-617-0390 (TTY/TDD 1-877-617-0392), Fax 1-866-811-3255. You can file a *grievance* by mail, fax, or email. If you need help filing a *grievance*, Ambetter from Arkansas Health & Wellness is available to help you. You can also file a civil rights *complaint* with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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