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of North Carolina Inc.

2021 Evidence of Coverage

AmbetterofNorthCarolina.com

77264NC001

Ambetter of North Carolina Inc.

Home Office: 200 E. Randolph Street, Suite 3600, Chicago, IL 60601

Individual Member HMO Policy

Ambetter of North Carolina Inc. is a health maintenance organization (HMO), organized under the laws of the State of North Carolina, providing healthcare coverage for *members*. In this *policy,* the terms *"you"*, *"your",* or *"yours"* will refer to the *member* or any *dependents* enrolled in this *policy*. The terms *"we," "our,"* or *"us"* will refer to Ambetter of North Carolina Inc.

This *policy* is a closed panel network HMO. This means that services rendered by out-of-network providers will not be covered except in limited situations described in the *eligible service expense* definition, found on page 15 of the *policy*.

This *policy* is a legal contract between *you* and *us*. Read *your policy* carefully.

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 *member*, 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 *policy* 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 policies 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 reach demonstrated capacity in a *service area* in whole or in part; or (3) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *policy* benefits.

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 *members,* type and level of benefits, and place of *residence* on the premium due date are some of the factors used in determining *your* premium rates. *We* have the right to change premiums.

At least 60 days' notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *policy* or a change in a *member's* health. While this *policy* is in force, *we* will not restrict coverage already in force. If *we* discontinue offering and decide not to renew all polices issued on this form, with the same type and level of benefits, for all residents of the

state where *you* reside, *we* will provide a written notice to *you* at least 90 days prior to the date that *we* discontinue coverage.

Important Cancellation Information – Please read the provision entitled, "Termination," found on page 71 of the *policy*.

This *policy* contains *prior authorization* requirements. *You* may be required to obtain a referral from a *primary care provider* in order to receive care from a *specialist provider*. *You* do not need a referral from *your network primary care provider* for: 1) obstetrical or gynecological treatment from a *network* obstetrician or gynecologist; 2) *network* pediatrician; or 3) *network provider* who has been designated as your *network primary care provider* to treat *your* serious or chronic degenerative, disabling, or life-threatening disease or condition. Benefits may be reduced or not covered if the requirements are not met. Please refer to the *Schedule of Benefits* and the Prior Authorization Section.

TEN DAY RIGHT TO RETURN POLICY

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

Ambetter of North Carolina Inc.

Catherine M. Campbell

Catherine M. Campbell
Plan President

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Introduction

Welcome to Ambetter of North Carolina Inc.! *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 health care services *we* cover.
- The portion of *your* health care costs *you* will be required to pay.

This *policy*, the *Schedule of Benefits*, the application as submitted to the Health Insurance Marketplace, and any amendments and riders attached shall constitute the entire *policy* 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 for *you* in the Definitions section. This *policy* also contains exclusions, so please be sure to read this entire *policy* carefully.

How to Contact Us
Ambetter of North Carolina Inc.
Attn: Ambetter Department
12515-8 Research Blvd.,
Suite 400
Austin, TX 78759

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST
Member Services **1-833-863-1310**
Relay 711
Fax **1-833-537-2330**
Emergency **911**
24/7 Nurse Advice Line **1-833-863-1310**

Interpreter Services
Ambetter of North Carolina Inc. 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 representatives that speak Spanish and medical interpreters to assist with languages other than English via phone. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpretation services, please call Member Services at 1-833-863-1310 or for the hearing impaired (Relay 711).

Member Rights and Responsibilities

We are committed to:

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

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

1. Participate with *your provider* and *medical practitioners* in decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or *your* legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our network* of *providers* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your provider* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care provider* about what might be wrong (to the level known), treatment and any known likely results. *Your primary care provider* can tell *you* about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your provider* will ask for *your* approval for treatment unless there is an *emergency* and *your* life and health are in serious danger.
8. Make recommendations regarding *member's* rights, responsibilities, and policies.
9. Voice *complaints* or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your provider*(s) of the medical consequences.
11. See *your* medical records.
12. Be kept informed of *covered* and non-*covered services*, program changes, how to access services, *primary care provider* assignment, *providers*, advance directive information, referrals and *authorizations*, benefit denials, *member* rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such

notices shall include:

a. Any changes in clinical review criteria; or
b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.

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

    a. Living Will;
    b. Health Care Power of Attorney; or
    c. "Do Not Resuscitate" Orders. *Members* also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

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

your provider. *You* may change *your primary care provider* verbally or in writing by contacting *our* Member Services Department.

7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *provider*.
11. Tell *your* health care professional and *provider* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care provider* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies, and procedures.
13. Use any emergency room only when *you* think *you* have a medical *emergency*. For all other care, *you* should call *your primary care provider*.
14. When *you* enroll in this coverage, give all information about any other medical coverage *you* have. If, at any time, *you* get other medical coverage besides this coverage, *you* must tell the entity with which *you* enrolled.
15. Pay *your* monthly premiums on time and pay all *deductible amounts, copayment amounts*, or *cost sharing percentages* at the time of service.
16. Inform the entity in which *you* enrolled for this *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 *ambetterofnorthcarolina.com*. *We* have plan *providers*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* with *your* healthcare services. *You* may find any of *our network providers* by completing the "Find a Provider" function on *our* website and selecting the Ambetter Network. There *you* will have the ability to narrow *your* search by *provider* specialty, zip code, gender, languages spoken and whether or not they are currently accepting new patients. *Your* search will produce a list of *providers* based on *your* search criteria and will give *you* other information such as name, address, phone number, office hours, and specialty and board certifications.

At any time, *you* can request a copy of the provider directory at no charge by calling Member Services at 1-833-863-1310 (Relay 711). In order to obtain benefits, *you* may designate a *primary care provider* for each *member. We* can help *you* pick a *primary care provider* (*PCP*). *We* can make *your* choice of *primary care provider* effective on the next business day.

Call the *primary care provider's* office if *you* want to make an appointment. If *you* need help, call Member Services at 1-833-863-1310 (Relay 711). *We* will help *you* make the appointment.

Member ID Card
When *you* enroll, *we* will mail *you* a Member ID card after *we* receive *your* completed enrollment materials and *you* have paid *your* initial premium payment. This card is proof that *you* are enrolled in the Ambetter of North Carolina Inc. 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 1-833-863-1310 (Relay 711). *We* will send *you* another card.

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

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

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

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Providing programs and educational items about general healthcare and specific diseases.
3. Sending reminders to *members* to get annual tests such as a physical exam, cervical cancer screening, breast cancer screening, and immunizations.
4. A Quality Improvement Committee 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*:

Acute rehabilitation means rehabilitation for patients who will benefit from an intensive, multidisciplinary rehabilitation program. Patients normally receive a combination of therapies such as physical, occupational, and speech therapy as needed and are medically managed by specially trained physicians. Rehabilitation services must be performed for three or more hours per day, five to seven days per week, while the *covered person* is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *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 Health Insurance Marketplace. *Advanced premium tax credits* can be used right away to lower *your* monthly premium costs. If *you* qualify, *you* may choose how much *advanced premium tax credit* to apply to *your* premiums each month, up to the maximum amount. If the amount of *advanced premium tax credits you* receive for the year is less than the total tax credit *you're* due, *you'll* get the difference as refundable credit when *you* file *your* federal income tax return. If *your advanced premium tax credits* for the year are more than the total amount of *your* premium tax credit, *you* must repay the excess *advanced premium tax credit* with *your* tax return.

Adverse benefit determination means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; and (ii) In the case of a plan providing disability benefits, the term "*adverse benefit determination*" also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. An *adverse benefit determination* includes a non-certification.

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

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

Allowed amount (also *Eligible Service Expense*) means 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.

Ambetter means Ambetter of North Carolina Inc., a health maintenance organization (HMO), which is organized under the laws of the State of North Carolina, providing healthcare coverage for *members*.

Appeal means a request to reconsider a decision about the *member's* benefits where either a service or claim has been denied.

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

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

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

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

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

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

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

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

Billed amount means the amount a *provider* charges for a service.

Calendar year means 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 means a program in which a registered nurse, known as a care manager, assists a *member* through a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and health care benefits available to a *member*. *Care management* is instituted when mutually agreed to by *us*, the *member* and the *member's provider*.

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of *medically necessary* transplants or other services such as cancer, bariatric, or infertility; and

2. Has agreed with *us* or an entity designated by *us* to meet quality of care criteria on a cost efficient basis. The fact that a *hospital* is a *network provider* does not mean it is a *Center of Excellence.*

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

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

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

Complications of pregnancy means:

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

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

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

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

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

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

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

1. Provided or incurred while the *member's* coverage is in force under this *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* or domestic partner, and each *eligible child*:

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

Creditable coverage means accepted health insurance cover carried prior to *Ambetter's* coverage which can be group health insurance, an employee welfare benefit plan to the extent that the plan provides medical care to employees and/or their dependents directly or through insurance, reimbursement, or otherwise, individual health insurance, short-term limited duration health insurance coverage, public health plan, Children's Health Insurance Program (CHIP), Medicare, Medicaid, and any other coverage defined as creditable coverage under state or federal law. Creditable coverage does not include coverage consisting solely of excepted benefits.

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

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

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

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

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

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

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

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

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

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

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

Effective date means the date a *member* becomes covered under this *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;
4. A child placed with *you* for foster care;
5. A child for whom legal guardianship has been awarded to *you* or *your spouse*; or
6. A stepchild.

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

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

1. For *network providers*: When a *covered service* is received from a *network provider*, the *eligible service expense* is the contracted fee with that *provider*.
2. For *non-network providers*:
    a. When a *covered service* is received from a *non-network provider* as a result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the *provider* as payment in full (*you* will not be billed for the difference between the negotiated fee and the *provider's* charge). However, if the *provider* has not agreed to accept a negotiated fee with *us* as payment in full, the *eligible service expense* is the greatest of the following: (*you* will not be *balance billed* by the provider, if *you* are, please contact Member Services)
        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.
    b. When a *covered service* is received from a *non-network provider* as *approved* or *authorized* by *us* and is not the result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the *provider* as payment in full (*you* will not be billed for the difference between the negotiated fee and the *provider's* charge). If there is no negotiated fee agreed to by the *provider* with *us*, the *eligible service expense* is the greater of (1) the amount that would be paid under Medicare, or (2) the contracted amount paid to *network providers* for the *covered service*. If there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts. *You* will not be *balance billed* by the provider, if *you* are, please contact Member Services.
    c. When a *covered service* is received from a *non-network provider* because the service or supply is not available from any *network provider* in *your service area* and is not the result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that the *provider* has agreed to accept as payment in full (*you* will not be billed for the difference between the negotiated fee and the *provider's* charge). If there is no negotiated fee agreed to by the *provider* with *us*, the *eligible service expense* is the greater of (1) the amount that would be paid under Medicare, or (2) the contracted amount paid to *network providers* for the *covered service*. If there is more than one contracted amount with *network providers* for the *covered*

service, the amount is the median of these amounts. *You* will not be *balance billed* by the provider, if *you* are, please contact Member Services.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or acute symptoms resulting from or associated with a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

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

Emergency services means health care items and services furnished or required to screen for or treat an *emergency* until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department of a *hospital.*

Follow-up care is not considered emergency care. Benefits are provided for treatment of *emergency* medical conditions and *emergency* screening and stabilization services without *prior authorization*. Benefits for *emergency* care include facility costs and *provider* services, and supplies and *prescription drugs* charged by that facility. *You* must notify *us* or verify that *your provider* has notified *us* of *your* admission to a *hospital* within 24 hours or within 24 hours of post discharge. When *we* are contacted, *you* will be notified whether the *inpatient* setting is appropriate, and if appropriate, the number of days considered *medically necessary*. By contacting *us*, *you* may avoid financial responsibility for any *inpatient* care that is determined to be not *medically necessary* under *your* Plan. If *your provider* does not contract with *us*, *you* will be financially responsible for any care *we* determine is not *medically necessary*. Care and treatment provided once *you* are *medically stabilized* is no longer considered *emergency* care. Continuation of care from a non-participating *provider* beyond that needed to evaluate or stabilize *your* condition in an *emergency* will be covered as a non-*network* service unless *we authorize* the continuation of care and it is *medically necessary*.

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

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

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

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

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

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

Foster child means a minor over whom a guardian has been appointed by the clerk of superior court of any county in North Carolina or the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction.

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

If no credible scientific evidence is available, then standards based on physician specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered service* 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*.

Generic prescription drug means a drug that has same active ingredient as brand name drug. Food and Drug Administration (FDA) rates *generic prescription drugs* as equivalent to brand name drugs in safety and efficacy. This tier may cover select Over-The-Counter (OTC's) and branded drug products.

Grievance means a written complaint submitted by a member (or a member's *authorized representative* or provider acting on the member's behalf) about any of the following: (a) *Ambetter's* decisions, policies, or actions related to availability, delivery, or quality of health care services; (b) claims payment or handling; or reimbursement for services, (c) the contractual relationship between a member and *Ambetter*; or (d) the

outcome of an *appeal* of a non-certification under N.C. Gen. Stat. 58-50-61. A written complaint submitted about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a grievance if the exclusion of the specific service requested is clearly stated in the evidence of coverage. A grievance does not include a non-certification.

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

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

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

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

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

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

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

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

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

Hospice care program means a coordinated, interdisciplinary program prescribed and supervised by a *provider* to meet the special physical, psychological, and social needs of a *terminally ill member* and those of his or her *immediate family.*

Hospital means an institution that:

1. Operates as a *hospital* pursuant to law;
2. Operates primarily for the reception, care, and treatment of sick or injured persons as *inpatients*;
3. Provides 24-hour nursing service by registered nurses on duty or call;
4. Has staff of one or more *physicians* available at all times;
5. Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or in facilities available to it on a prearranged basis; and

6. Is not primarily a long-term care facility; a *skilled nursing facility*, nursing, rest, *custodial care*, or convalescent home; a halfway house, transitional facility, or *residential treatment facility;* a place for the aged, drug addicts, alcoholics, or runaways; a facility for wilderness or outdoor programs; or a similar establishment.

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

Infertility means the inability after 12 consecutive months of unsuccessful attempts to conceive a child despite regular exposure of female reproductive organs to viable sperm.

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

Immediate family means the parents, *spouse*, eligible child (natural, adopted or foster), or siblings of any *member*, or any person residing with a *member*.

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

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

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

Loss means an event for which benefits are payable under this *policy*. A *loss* must occur while the *member* is covered 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 an individual incurs a claim that would meet or exceed a lifetime limit on all benefits;
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in 26 CFR § 54.9802-1(d)) that includes the individual;
6. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent; and
7. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

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

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

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

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

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

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

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

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

Medical practitioner includes but is not limited to a *provider*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of *providers* that are NOT *medical practitioners*, by definition of the *policy:* acupuncturist, speech therapist, occupational therapist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, *emergency* medical technician, social worker, child counselor, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Medically necessary means those *covered services* or supplies that are:

1. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and except as allowed for clinical trials under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes;
2. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms;
3. Within generally accepted standards of medical care in the community; and
4. Not solely for the convenience of the *member*, the *member's* family, or the *provider*.

For *medically necessary* services, nothing in this definition precludes *us* from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

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

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

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

Member or ***Covered person*** means an individual covered by the health plan including an enrollee, subscriber, or policy holder. "Covered person" includes another person other than the *covered person's* provider, who is authorized to act on behalf of a *covered person*.

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

Necessary medical supplies means medical supplies that are:

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

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

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

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

Network provider means a *medical practitioner* who is identified in the most current list for the *network* shown on *your* identification card.

Non-Certification means a determination by *Ambetter* or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet *Ambetter's* requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of emergency services in N.C.G.S. 58-3-190, and the requested service is therefore denied, reduced, or terminated. A "non-certification" is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. A "non-certification" includes any situation in which *Ambetter* or its designated agent makes a decision about a member's condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision.

Non-elective cesarean section means:

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

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

Non-preferred prescription drug means a drug that currently does have a generic equivalent, branded drug that is therapeutically equivalent to another branded drug and that we deemed non-preferred or generic product that is therapeutically equivalent to another generic products and we deemed non-preferred.

Ongoing special condition means 1) in the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm; 2) in the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time; 3) in the case of pregnancy, pregnancy from the start of the second trimester; or 4) in the case of terminal illness, an individual has a medical prognosis that the individual's life expectancy is six months or less.

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

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

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

Outpatient surgical facility means any facility with a medical staff of *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 *provider* offices.

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

Period of extended loss means a period of consecutive days:

1. Beginning with the first day on which a *member* is a *hospital inpatient;* and
2. Ending with the 30th consecutive day for which he or she is not a *hospital inpatient.*

Physician or ***Provider*** means a licensed *medical practitioner* who is practicing within the scope of his or her licensed authority in treating a bodily *injury* or sickness and is required to be covered by state law. A *physician* 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.

Prospective 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.

Preferred brand prescription drug means a drug that currently does not have a generic equivalent or a branded drug that is therapeutically equivalent to another branded drug and that we deemed preferred.

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

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

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

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

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

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

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

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

Provider facility means a *hospital, rehabilitation facility*, or *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 Health Insurance Marketplace through which such plan is offered in accordance with the process described in subpart K of part 155.

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

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

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

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

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

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

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

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

Rescission of a 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 health care* services provided temporarily to a *member* in order to provide relief to the *member's immediate family* or other caregiver.

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

Service Area means a geographical area, made up of counties, where *we* have been authorized by the State of North Carolina to sell and market *our* health plans. Those counties are: Alamance, Alexander, Alleghany, Bladen, Caswell, Chatham, Cumberland, Davidson, Davie, Durham, Forsyth, Franklin, Granville, Guilford, Harnett, Hoke, Iredell, Johnston, Lee, Montgomery, Moore, Orange, Person, Randolph, Richmond, Robeson, Rockingham, Sampson, Scotland, Stokes, Vance, Wake, Warren, Wilkes and Yadkin. *You* can receive precise *service area* boundaries from *our* website or *our* Member Services department.

Sexual dysfunction means any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.

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 *provider* and the direct supervision of a registered nurse;
3. Maintains a daily record on each patient;
4. Has an effective *utilization review* plan;
5. Provides each patient with a planned program of observation prescribed by a *provider*; and
6. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing *generally accepted standards* of medical practice for that condition.

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 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, prevent, or treat certain types of symptoms and conditions related to their specific field of expertise.

Specialty prescription drug means drugs used to treat complex, chronic conditions that may require special handling, storage, or clinical management.

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

Stabilize means medical care appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the Health Care Financing Administration ("HCFA") interpretative guidelines, policies, and regulations pertaining to responsibilities of hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. 1395dd), including *medically necessary* services and supplies to maintain stabilization until the person is transferred to an appropriate setting.

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

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

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

Surrogacy 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; and/or
3. Rectovaginal 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.

The term does not include the delivery of health care services by use of the following:

1. A telephone transmitter for trans-telephonic monitoring; or,
2. A telephone or any other means of communication for the consultation from one (1) *provider* to another *provider*.

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

Terminally ill means a *provider* has given a prognosis that a *member* has six months or less to live.

Third party means a person or other entity that is or may be obligated or liable to the *member* for payment of any of the *member's* expenses for *illness* or *injury*. The term *third party* includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or

program; and an insurance company. However, the term *third party* will not include any insurance company with a policy under which the *member* is entitled to benefits as a named insured person or an insured *dependent member* of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit *our* right to recover from these sources.

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

Transcranial Magnetic Stimulation (TMS) 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.

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

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

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

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

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

Dependent Member Coverage

Dependent Member Eligibility
Your dependent members become eligible for insurance on the latter of:

1. The date *you* became covered under this *policy;*
2. The date of marriage to add a *spouse*;
3. The date of an eligible newborn's birth;
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; or
5. The date that a foster child is placed with *you* or *your spouse* and *you* or *your spouse* are appointed as guardian or custodian of that foster child and have assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with *you* or *your spouse* on more than a temporary or short-term basis.

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

Coverage for a Newborn Child
An eligible child born to you or your family member will be covered from the time of birth until the 31st day after its birth, unless we have received notice from the entity that you have enrolled (either the Health Insurance Marketplace or *us*). Each type of *covered service* incurred by the newborn child will be subject to the *cost sharing* amount listed in the Schedule of Benefits.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth. The required premium will be calculated from the child's date of birth. If notice of the newborn is given to *us* by the Health Insurance Marketplace within the 31 days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 days after the birth of the child. If notice is not given within the 31 days from birth, *we* will charge an additional premium from the date of birth. If notice is given by the Health Insurance Marketplace within 60 days of the birth of the child, the *policy* may not deny coverage of the child due to failure to notify *us* of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st day after its birth, unless *we* have received notice by the Health Insurance Marketplace of the child's birth.

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

The child will be covered for *loss* due to *injury* and *illness* including medically diagnosed congenital defect(s) and *medically necessary* care and treatment of conditions existing prior to the date of *placement.*

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

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

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

Coverage for a Foster Child
An *eligible child* legally placed in foster care with *you* or *your spouse* will be covered from the date of *placement* until the 31st day after *placement*, unless the *placement* is disrupted and the child is removed from *your* or *your spouse's* custody.

The child will be covered for *loss* due to *injury* and *illness* including medically diagnosed congenital defect(s) and *medically necessary* care and treatment of conditions existing prior to the date of *placement.*

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

As used in this provision, "*placement*" means physically residing with *you* or *your spouse*, appointed as guardian or custodian of a *foster child* as long as that guardian or custodian has assumed the legal obligation for total or partial support of the *foster child* with the intent that the *foster child* reside with *you* or *your spouse* on more than a temporary or short-term basis.

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

Ongoing Eligibility

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

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

If *you* have material modifications (examples include a change in life event such as marriage, death, or other change in family status), or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace (Marketplace) at www.healthcare.gov or 1-800-318-2596. If *you* enrolled through *Ambetter, you* can contact Member Services at 1-833-863-1310 (Relay 711).

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

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

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

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

Special and Limited Enrollment
A *qualified individual* has 60 days to report a qualifying event to the Health Insurance Marketplace or by using *Ambetter's* Enhanced Direct Enrollment tool, and could be granted a 60 day Special Enrollment Period as a result of one of the following events:

1. A *qualified individual* or *dependent loses minimum essential coverage*, non-calendar year group of individual health insurance coverage, pregnancy-related coverage, access to healthcare services through coverage provided to a pregnant enrollee's unborn child, or medically needed coverage;
2. A *qualified individual* gains a *dependent* or becomes a *dependent* through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order. In the case of marriage, at least one *spouse* must demonstrate having minimum essential coverage as described in 26 C.F.R. 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage;

3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
4. An individual who is no longer incarcerated or whose incarceration is pending the disposition of charges;
5. A *qualified individual's* enrollment or non-enrollment in a *qualified health plan* is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace or HHS, or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
6. An enrollee adequately demonstrates to the Health Insurance Marketplace that the *qualified health plan* in which he or she is enrolled substantially violated a material provision of its policy in relation to the enrollee's decision to purchase the *qualified health plan* based on plan benefits, *service area*, or premium;
7. An individual is determined newly eligible or newly ineligible for *advance premium tax credits* or has a chance in eligibility for *cost sharing reductions*, regardless of whether such individual is already enrolled in a *qualified health plan*;
8. A *qualified individual* or enrollee gains access to new *qualified health plans* as a result of a permanent move;
9. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
10. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a *qualified health plan* or change from one *qualified health plan* to another one time per month; or
11. A *qualified individual* or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide;
12. A qualified individual or dependent is a victim of domestic abuse or spousal abandonment and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
13. A qualified individual or dependent is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 days after the qualifying event;
14. At the option of the Health Insurance Marketplace, a qualified individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a qualified health plan through the Health Insurance Marketplace following termination of Health Insurance Marketplace enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. §155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence; or
15. A qualified individual newly gains access to an employer sponsored individual coverage HRA or a Qualified Small Employer Health Reimbursement Arrangement (HRA).

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

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

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. In the case that the prior coverage terminating immediately before the *effective date*, does not furnish benefits for the hospitalization after the termination, then the "Continuity of Care – Transitional Period: Scheduled Surgery, Organ Transplantation, or Inpatient Care" provision on page 73 will apply.

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-network* hospital, claims will be paid at the *Ambetter* allowable and *you* may be billed for any balance of costs above the *Ambetter* allowable.

Premiums

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

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

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

When a *member* is not receiving a premium subsidy:

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

Third Party Payment of Premiums or Cost Sharing
Ambetter requires each 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; or
4. Family members.

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

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

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

Change or Misstatement of Residence
If *you* change *your residence*, *you* must notify the Health Insurance 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 or Nicotine Use
The answer to the tobacco or nicotine question on the application is material to *our* correct underwriting. If a *member's use of tobacco or nicotine* has been misstated on the *member's* application for coverage under this *policy, we* have the right to rerate the *policy* back to the original *effective date*.

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

Prior Authorization

Ambetter reviews services to ensure the care you receive is the best way to help improve your health condition. Utilization review includes:

- Pre-service or prior authorization review – occurs when a medical service has been pre-approved by Ambetter
- Concurrent review – occurs when a medical service is reviewed as they happen (e.g., inpatient stay or hospital admission)
- Retrospective review – occurs after a service has already been provided.

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

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

1. Receive a service or supply from a *non-network provider;*
2. Are admitted into a *network* facility by a *non-network provider;* or
3. Receive a service or supply from a *network provider* to which *you* or *your dependent member* were referred to by a *non-network provider.*

Prior Authorization requests (medical and behavioral health) 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*, *skilled nursing* or *rehabilitation facility*, or *hospice* facility.
2. At least 30 days prior to the initial evaluation for organ transplant services.
3. At least 30 days prior to receiving clinical trial services.
4. Within 24 hours of any inpatient admission, including emergent inpatient admissions.
5. At least 5 days prior to the start of *home health care*, except those *members* needing *home health care* after *hospital* discharge.

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

1. For immediate request situations, within 1 business day, when the lack of treatment may result in an emergency room visit or *emergency* admission.
2. For urgent concurrent review within 24 hours of receipt of the request.
3. For urgent pre-service reviews, within 72 hours from date of receipt of request.
4. For non-urgent pre-service reviews within 3 business days of receipt of all necessary clinical information.
5. For post-service or retrospective reviews, within 30 calendar days of receipt of the request.
6. Except in cases of fraud or material misrepresentation, *we* will be bound by *our* initial approval of *medically necessary* services or supplies.

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

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

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

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

Services from Non-Network Providers
Except for *emergency* medical services, *we* do not normally cover services received from *non-network providers*. If a situation arises where a *covered service* cannot be obtained from a *network provider* located within a reasonable distance, *we* may provide a *prior authorization* for *you* to obtain the service from a *non-network provider* at no greater cost to *you* than if *you* went to a *network provider*. If *covered services* are not available from *network provider* ***you*** **or** ***your primary care provider*** **must request** ***prior authorization*** **from** ***us*** **before** ***you*** **may receive services from a** ***non-network provider*****.** Otherwise *you* will be responsible for all charges incurred.

Coverage received from *non-network providers* will be covered in the following limited situations:

1. When a *covered service* is received from a *non-network provider*, as a result of an emergency;
2. When a *covered service* is received from a *non-network provider*, not as a result of an emergency, but has been *approved* or *authorized* by *us*; and
3. When a *covered service* is received from a *non-network provider* because the service or supply is not available from a *network provider* in the *member's* service area, but is not an emergency.

In these limited situations, *you* will be entitled to the *covered services* as described under this *policy* and *you* will only be responsible for the amount that *you* would have been charged if *you* received the *covered services* from a *network provider*.

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*. *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*. Should you receive *covered services* from a *non-network hospital*-based provider at a *network* facility, we will work with the provider on payment of *covered services* to ensure that you are not responsible for an amount in excess of what you would pay to a *network provider*. You should not be billed for amounts in excess of what you would pay to a *network provider*. If you do receive a bill for such amounts, please contact Member Services at 1-833-863-1310 (Relay 711).

In cases of emergency, if *you* go to an in-network facility and an in-network hospital based provider is not reasonably available to provide a *covered service*, then *you* will not be subject to *balance billing*. If *you* receive a bill from the provider, please contact Member Services at 1-833-863-1310 (Relay 711). *We* will work directly with the provider to make sure that *you* are not *balance billed.*

Except for emergency medical services, we do not normally cover services *you* may have received from non-network providers. In the event *our network* is unable to reasonably meet a *member's* needs, the *member* should seek *prior authorization* for treatment to be provided by out-of-network provider(s) at the in-

network facility. If prior authorized, *eligible service expenses* for benefits provided by approved out-of-network provider(s) will be covered by *Ambetter* at rates that are comparable to in-network rates. Should *you* receive a bill from the provider, please contact Member Services at 1-833-863-1310 (Relay 711). *We* will work directly with the provider to make sure that *you* are not *balance billed.*

Cost Sharing Features

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

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

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

Coinsurance Amount
A *coinsurance* amount is *your* share of the cost of a service after your deductible has been met. *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 meeting *your maximum out-of-pocket amount*. When the annual *maximum out-of-pocket* has been met, additional *covered service expenses* will be 100%.

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

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

Refer to your Schedule of Benefits for Coinsurance Percentage and other limitations
The amount provided or payable will be subject to:

1. Any specific benefit limits stated in the *policy*; and
2. A determination of *eligible service expenses*.

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

NOTICE: *Your* actual expenses for *covered services* may exceed the stated *coinsurance* percentage or *copayment* amount because actual provider charges may not be used to determine plan and *member* payment obligations.

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

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

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

This Evidence of Coverage is administered by Ambetter of North Carolina Inc. This entity is not an HSA trustee, HSA custodian or a designated administrator for HSAs. Ambetter of North Carolina Inc., its designee, and its affiliates do not provide tax, investment or legal advice to *members*.

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

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

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

Access to Care

Primary Care Provider
In order to obtain benefits, *you* may 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 contract. You should get to know *your PCP* and establish a healthy relationship with them. *Your PCP* will:

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

Adults may designate an OB/GYN as a *network primary care provider*. *You* may designate a pediatrician as a *network primary care provider* for *your dependent member* under 18 years old. However, *you* may not change *your* selection more frequently than once each month. If *you* do not select a *network primary care provider* for each *member,* one will be assigned. *You* may obtain a list of *network primary care providers* at *our* website or by contacting *our* Member Services department.

Members diagnosed with a serious or chronic degenerative, disabling, or life-threatening disease or condition, either of which requires specialized medical care may designate a *specialist*, with expertise in treating the disease or condition, as a *network primary care provider*. If *we* determine that the *member's* care would not be appropriately coordinated by the designated *specialist*, *we* may deny access to that *specialist* as a *network primary care provider*.

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.

Contacting Your Primary Care Physician
To make an appointment with *your PCP*, call his/her office during business hours and set up a date and time. If *you* need to cancel or change *your* appointment, call 24 hours in advance. At every appointment, make sure *you* bring *your member* ID card and a photo ID.

Should *you* need care outside of *your* PCP's office hours, *you* should call *your* PCP's office for information on receiving after hours care in *your* area. If *you* have an urgent medical problem or question or cannot reach *your PCP* during normal office hours, call our 24/7 nurse advice line at 1-877-687-1180 (TTY/TDD 1-877-941-9231). 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.

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 *ambetterofnorthcarolina.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.

Referral Required For Maximum Benefits
You do not need a referral from *your network primary care provider* for: 1) obstetrical or gynecological treatment from a *network* obstetrician or gynecologist; 2) *network* pediatrician; or 3) *network provider* who has been designated as your *network primary care provider* to treat *your* serious or chronic degenerative, disabling, or life-threatening disease or condition. For all other *network specialists, you* may be required to obtain a referral from *your network primary care provider* for benefits to be payable under *your policy* or benefits payable under this *policy* may be reduced. Please refer to the *Schedule of Benefits*.

Network Availability
Your network is subject to change upon advance written notice. A *network service area* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

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

Non-Emergency Services
If *you* are traveling outside of the North Carolina 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 North Carolina by searching the relevant state in our provider directory at *ProviderSearch.AmbetterHealth.com*. Not all states have Ambetter plans. If *you* receive care from an Ambetter provider outside of the service area, *you* may be required to receive *prior authorization* for non-emergency services. Contact Member Services at the phone number on *your* ID card for further information.

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

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

New Technology
Health technology is always changing. If *we* think a new medical advancement can benefit *our* members, *we* evaluate it for coverage. These advancements include:

- New technology
- New medical procedures
- New drugs
- New devices
- New application of existing technology

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

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

Major Medical Expense Benefits

The plan provides coverage for healthcare services for a *member* or covered dependents. Some services require *prior authorization*.

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

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

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

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

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

Benefits for air ambulance services are limited to:

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

Exclusions
No benefits will be paid for:

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

Autism Spectrum Disorder Benefits
Ambetter will provide coverage for the screening, diagnosis and treatment of autism spectrum disorder. Generally recognized services prescribed in relation to *autism spectrum disorder* by a *provider* or behavioral health practitioner in a treatment plan recommended by that *provider* or behavioral health practitioner.

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

- evaluation and assessment services;
- *applied behavioral 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;
- *habilitation* services for individuals with a diagnosis of *autism spectrum disorder*; or
- medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

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

Diabetic Care

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

Dialysis Services

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

Covered services included:

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

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

Durable Medical Equipment, Prosthetics, and Orthotic Devices

The supplies, equipment, and appliances described below are *covered services* under this benefit. If the supplies, equipment, and appliances include comfort, luxury, or convenience items or features which exceed what is *medically necessary* in *your* situation or needed to treat *your* condition, reimbursement will

be based on the maximum allowable amount for a standard item that is a *covered service*, serves the same purpose, and is *medically necessary*. Any expense that exceeds the maximum allowable amount for the standard item which is a *covered service* is *your* responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates *your* condition. Repair, adjustment, and replacement of purchased equipment, supplies, or appliances as set forth below may be covered, as *approved* by *us*. The repair, adjustment, or replacement of the purchased equipment, supply, or appliance is covered if:

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

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

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

Benefits for repairs and replacement do not include the following:

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

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

Durable Medical Equipment

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

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

1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for IV fluids and medicine.
5. Glucometer.
6. Tracheotomy tube.
7. Cardiac, neonatal, and sleep apnea monitors.
8. Augmentative 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/cold pack pump.
3. Raised toilet seats.
4. Rental of equipment if the *member* is in a facility that is expected to provide such equipment.
5. Translift chairs.
6. Treadmill exerciser.
7. Tub chair used in shower.

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

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

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

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

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

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

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

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

1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).

4. Splints (extremity).
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.
10. Devices for correction of positional plagiocephaly.

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

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

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

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

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

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

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

1. Aids and supports for defective parts of the body including, but not limited to, internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per benefit period, as required by the Women's Health and Cancer Rights Act. Maximums for *prosthetic devices*, if any, do not apply.
3. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
4. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are *covered services*. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to

one eye or if cataracts are removed from only one eye and the *member* selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.

5. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
6. Restoration prosthesis (composite facial prosthesis).
7. Wigs (the first one following cancer treatment, not to exceed one per benefit period).

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

1. Dentures, replacing teeth, or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings (except for *members* with diabetes), garter belts, arch supports, and corsets.
4. Wigs (except as described above following cancer treatment).

Habilitation, Rehabilitation, and Skilled Nursing Facility Expense Benefits
Covered service expenses include services provided or expenses incurred for *habilitation* or *rehabilitation* services (including *cardiac rehabilitation* and pulmonary rehabilitation) or confinement in a *skilled nursing facility*, subject to the following limitations:

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

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

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

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

Home Health Care Service Expense Benefits
Covered service expenses and *supplies* 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 includes the following:

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

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

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

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

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

1. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
2. Daily room and board and nursing services while confined in an *intensive care unit*.
3. *Inpatient* use of an operating, treatment, or recovery room.
4. Outpatient use of an operating, treatment, or recovery room for *surgery.*
5. Services and supplies, including drugs and medicines, which are routinely provided by the *hospital* to persons for use only while they are *inpatients.*
6. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See *your Schedule of Benefits* for limitations.

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

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

Infertility Services
Covered services for infertility treatment are limited to diagnostic testing to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy and semen analysis. Treatment of the underlying medical conditions that cause infertility (such as endometriosis, obstructed fallopian tubes and hormone deficiency) are considered a separate benefit. Treatment for infertility are limited to a lifetime maximum of three.

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

1. For *surgery* in a *provider's* office or at an *outpatient surgical facility,* including services and supplies.
2. Made by a *provider* for professional services, including *surgery.*
3. Made by an assistant surgeon.
4. For the professional services of a *medical practitioner.*
5. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
6. For diagnostic testing using radiologic, ultrasonographic, or laboratory services.
7. For chemotherapy and radiation therapy or treatment.
8. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
9. For the cost and administration of an anesthetic.
10. For oxygen and its administration.
11. For *surgery*. See the *Schedule of Benefits* for benefit levels or additional limits.
12. 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. Reconstructive breast surgery following a partial or total mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstructive breast surgery. The decision to discharge the *member* following a mastectomy is to be made by the treating physician and the *member*. The length of post mastectomy hospital stay is based on the unique characteristics, health and medical history of the *member*.
13. For *medically necessary chiropractic care* treatment on an outpatient basis only. *Chiropractic care* services are covered when a participating chiropractor finds that the services are *medically necessary* to treat or diagnose neuromusculoskeletal disorders on an outpatient basis. See the *Schedule of Benefits* for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *policy,* including the *deductible amount* and *percentage* provisions.
14. For the diagnosis, evaluation, and treatment of lymphedema, including complex decongestive therapy, and self-management training and education, if the treatment is determined to be *medically necessary* and is provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within the professional's scope of practice.
15. For *medically necessary* procedures involving any bone or joint of the face or head used to treat a condition which prevents normal functioning of the particular bone or joint involved and the condition is caused by congenital deformity, *illness* or bodily injury.
    a. Therapeutic procedures include splinting, intraoral prosthetic appliances used to reposition the bones or any other Coverage for *medically necessary* procedures involving any bone or joint of the jaw, face or nonsurgical treatment of temporomandibular joint dysfunction.
    b. Coverage is not provided for orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants, or root canals.
16. For the following types of tissue transplants:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.

e. Implantable prosthetic lenses, in connection with cataracts.

17. Family Planning for certain professional *provider* contraceptive services and supplies, including but not limited to vasectomy, tubal ligation, and insertion or extraction of prescribed FDA-approved contraceptive devices or drugs along with any associated *medically necessary* examinations.
18. *Medically necessary services* made by a *provider* in an *urgent care center*, including facility costs and supplies.
19. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
20. Allergy testing.
21. *Medically necessary* bariatric surgery.
22. *Medically necessary telehealth services* subject to the same clinical and *utilization review* criteria, plan requirements and limitations as the same health care services when delivered to an insured in person. *Telehealth Services* provided by Ambetter Virtual Care (services provided by Teledoc), are subject to $0 copay. *Telehealth Services* not provided by Ambetter Virtual Care would be subject to the same *cost sharing* as the same health care services when delivered to an insured in-person. Pursuant to federal regulation, the $0 cost share does not apply to *members* enrolled in an HSA-eligible plan. Please review *your Schedule of Benefits* to determine if *your* plan is HSA-eligible.
23. For *medically necessary* genetic blood tests.
24. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
25. For *medically necessary* allergy treatment.
26. *Medically necessary* confinement in a *skilled nursing facility*. See the *Schedule of Benefits* for benefit levels or additional limits.
27. For sterilization, including tubal ligation and vasectomies.
28. Coverage for certain services related to the diagnosis, treatment, and correction of any underlying organic cause of *sexual dysfunction*.
29. Congenital cleft lip and palate charges are *medically necessary* care and treatment including, but not limited to, oral and facial surgery, surgical management, and follow-up care made necessary because of a cleft lip and palate; prosthetic treatment such as obturator, speech appliances and feeding appliances; orthodontic treatment and management; prosthodontic treatment and management; otolaryngology treatment and management; audiological assessment, treatment and management performed by or under the supervision of a licensed doctor of medicine, including surgically implanted amplification devices and physical therapy assessment and treatment. If a *covered member* with a cleft lip and palate is covered by a dental policy, teeth capping, prosthodontics and orthodontics shall be covered by the dental policy to the limit of coverage provided and any excess thereafter shall be provided by this *policy*.
30. Newborn hearing screening ordered by the attending physician.

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 Addiction Equity Act of 2008.

Our behavioral health staff oversees the delivery of covered behavioral health and substance use disorder services for Ambetter of North Carolina Inc. Mental health services will be provided on an inpatient and outpatient basis and include treatable mental health conditions. These conditions affect the individual's ability to cope with the requirements of daily living. If you need mental health and/or substance use disorder treatment, you may choose any provider participating in our behavioral health network. You can search for in-network Behavioral Health *providers* by using *our* Find a Provider tool at *ambetterofnorthcarolina*.com or by calling Member Services at 1-833-863-1310 (Relay 711). *Deductible amounts*, *copayment* or *coinsurance* amounts and treatment limits for covered mental health and substance use disorder benefits will be applied in the same manner as physical health service benefits.

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

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

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

Inpatient

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

Outpatient

1. Individual and group therapy for mental health and substance use;
2. Psychological and Neuropsychological testing and assessment;
3. Medication Assisted Treatment – combines behavioral therapy and medications to treat substance use disorders;
4. Outpatient detoxification programs;
5. Evaluation and assessment for mental health and substance use;
6. Medication management services;
7. *Applied Behavioral Analysis* for treatment of autism;
8. Telemedicine;
9. Partial Hospitalization Program (PHP);
10. Intensive Outpatient Program (IOP);
11. Mental health day treatment;
12. Electroconvulsive Therapy (ECT);
13. Biofeedback;
14. Transcranial Magnetic Stimulation (TMS);
15. Assertive Community Treatment (ACT).

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

In addition, Integrated Care Management is available for all of *your* healthcare needs, including behavioral health and substance use. Please call 1-833-863-1310 (Relay 711) to be referred to a care manager for an assessment.

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.

Hospice Care Service Expense Benefits
Hospice care benefits are allowable for a *terminally ill member*, with a life expectancy of 6 months or less, receiving *medically necessary* care under a *hospice care program*. *Covered services* and supplies include:

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

Exclusions and Limitations
Any exclusion or limitation contained in the *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.

North Carolina State Mandated Benefits
The following North Carolina state mandated benefits are covered in the *policy*: Diagnosis and treatment of lymphedema, *emergency* care, minimum *inpatient* stay following delivery of a baby, minimum benefit offerings for alcoholism/drug abuse treatment, access to non-formulary drugs, hearing aids, bone mass measurements, *prescription drug* contraceptives and devices, colorectal cancer screenings, newborn hearing screening, ovarian cancer surveillance tests, mammograms and cervical cancer screening, prostate cancer screenings, reconstructive breast surgery following a mastectomy, congenital defects and abnormalities, certain clinical trials, anesthesia and *hospital* charges for certain dental procedures, diabetes, minimum coverage for mental illness, certain off-label use for cancer treatment and TMJ joint dysfunction.

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 temporomandibular joint disorders (TMJ).

Outpatient Medical Supplies Expense Benefits
Covered services and supplies for outpatient medical supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including *medically necessary* repairs or replacement to restore or maintain a *member's* ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per year per *covered person*.
3. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
4. For the rental of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint *surgery*.
5. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns.
6. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery.
7. For one hearing aid per hearing-impaired ear for *covered persons* once every thirty-six (36) months. The coverage shall include all *medically necessary* hearing aids and services that are ordered by a *provider* or an audiologist licensed in North Carolina. Only those persons authorized by law to fit hearing aids, including individuals licensed under Chapter 93D of the General Statutes, are eligible to fit a hearing aid under this provision. Coverage shall be as follows:
    a. Initial hearing aids and replacement hearing aids not more frequently than once every three years.
    b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the *covered person*.
    c. Services, including initial hearing aid evaluation, fitting, and adjustments, and supplies, including ear molds.
8. For the treatment of lymphedema, including equipment, supplies, and gradient compression garments if the treatment is determined to be *medically necessary* and is provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within the professional's scope of practice.
    a. Gradient compression garments:
        i. Require a prescription;
        ii. Are custom-fit for the covered individual; and
        iii. Do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products.
9. For bone mass measurement charges for diagnosis and evaluation of osteoporosis or low bone mass. Bone mass measurement will be covered if at least 23 months have elapsed since the last bone mass measurement was performed, except that *we* will provide coverage for follow-up bone mass measurement performed more frequently than every 23 months if the follow-up measurement is *medically necessary*. To qualify, one or more of the following criteria must be satisfied:
    a. An individual who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass;
    b. An individual with radiographic osteopenia anywhere in the skeleton;
    c. An individual who is receiving long-term glucocorticoid (steroid) therapy;
    d. An individual with primary hyperparathyroidism;

e. An individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies;
f. An individual who has a history of low-trauma fractures; or
g. An individual with other conditions or on medical therapies known to cause osteoporosis or low bone mass.

10. Nutritional counseling.

Pediatric Vision Expense Benefits

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

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

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

Services not covered:

1. Visual therapy;

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

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

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

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

As used in this section, *Standard Reference Compendia* means (a) The National Comprehensive Cancer Network Drugs & Biologics Compendium; (b) The Thomson Micromedex DrugDex; (c) The Elsevier Gold Standard's Clinical Pharmacology; or (d) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

You cannot refill a prescription until 80% of the supply has been used, except under certain circumstances during a state of emergency or disaster.

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 options, if a generic medication on the formulary is not suitable for *your* condition.

Please note, the formulary is not meant to be a complete list of the drugs covered under *your* prescription benefit. Not all dosage forms or strengths of a drug may be covered. This list is periodically reviewed and updated and may be subject to change. Drugs may be added or removed or additional requirements may be added in order to approve continued usage of a specific drug.

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the formulary. For the most current Ambetter Formulary or Prescription Drug List or for more information about our pharmacy program, visit *ambetterofnorthcarolina.com* (under “For Member”, “Pharmacy Resources”) or call Member Services at 1-833-863-1310 (Relay 711).

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

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

If *you* decide to have *your* prescription filled at an in-network pharmacy, *you* can use the Provider Directory to find a pharmacy near you. *You* can access the Provider Directory at *AmbetterofNorthCarolina.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 *AmbetterofNorthCarolina.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."

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

Non-Covered Services and Exclusions:
No benefits will be paid under this benefit subsection for services provided or expenses incurred:

1. For *prescription drug* treatment of erectile dysfunction or any enhancement of sexual performance, except as specifically mentioned in this *policy*.
2. For weight loss *prescription drugs* unless otherwise listed on the formulary.
3. For immunization agents, blood, or blood plasma, except when used for preventive care and listed on the formulary.
4. For medication that is to be taken by the *member,* in whole or in part, at the place where it is dispensed.
5. For medication received while the *member* is a patient at an institution, that has a facility for dispensing pharmaceuticals.
6. For a refill dispensed more than 12 months from the date of a *physician's* order.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for *investigational* or *experimental* drugs.

10. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program.
11. For more than a 30-day supply when dispensed in any one prescription or refill, or for some maintenance drugs up to 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply network. Specialty drugs and other select drug categories are limited to 30-day supply when dispensed by retail or mail order. Please note that only the 90-day supply is subject to the discounted *cost sharing*. Mail orders less than 90 days are subject to the standard *cost sharing* amount.
12. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
13. Foreign Prescription Medications, except those associated with an *emergency* medical condition while *you* are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this document if obtained in the United States.
14. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventive treatment is related to *member's* vacation during out of country travel. This provision does not prohibit coverage of treatment for aforementioned diseases.
15. For medications used for cosmetic purposes, except for the correction of congenital deformities.
16. For infertility drugs, except as otherwise provided in this *policy*.
17. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
18. Drugs or dosage amounts determined by *Ambetter* to be ineffective, unproven, or unsafe for the indication for which they have been prescribed, regardless of whether the drugs or dosage amounts have been approved by any governmental regulatory body for that use.
19. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
20. For any drug dispensed from a non-lock-in pharmacy while the *member* is in opioid lock-in program.
21. For any drug related to *surrogate* pregnancy.
22. For any drug used to treat hyperhidrosis.
23. For any injectable medication or biological product that is not expected to be self-administered by the *member* at *member's* place of *residence* unless listed on the formulary.

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.

Lock-In Program

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

Non-Formulary Prescription Drugs

Under Affordable Care Act, *you* have the right to request coverage of *prescription drugs* that are not listed on the plan formulary (otherwise known as "non-formulary drugs"). To exercise this right, please get in

touch with *your* medical practitioner. *Your* medical practitioner can utilize the usual *prior authorization* request process. See "Prior Authorization" below for additional details.

Prescription Drug Exception Process

Standard exception request

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

Expedited exception request

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

External exception request review

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

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

Preventive Care Expense Benefits

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

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. Examples of these services are screenings for breast cancer, cervical cancer, ovarian cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, prostate specific antigen testing, and screenings for child and adult obesity.
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual.

3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.
5. Covers without *cost sharing*:
    a. Screening for nicotine or *tobacco use*; and
    b. For those who use nicotine or *tobacco* products, cessation attempts. For this purpose, covering a cessation attempt includes coverage for:
        i. Nicotine or tobacco cessation counseling sessions of at least ten (10) minutes (including telephone counseling, group counseling, and individual counseling) without *prior authorization*; and
        ii. All Food and Drug Administration (FDA) approved nicotine or tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care *provider* without *prior authorization*.

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

Clinical Trial Coverage

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

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

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

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

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

- One of the National Institutes of Health (NIH);
- The Centers for Disease Control and Prevention;
- The Agency for Health Care Research and Quality;

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

In a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior, non-investigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational alternatives.

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

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

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

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

Mammography
Covered service expenses for routine screenings for breast cancer shall include screenings at the following intervals:

1. One or more mammograms a year, as recommended by a *provider*, for a *covered person* who is at risk for breast cancer. The *covered person* is deemed at risk for breast cancer if any one or more of the following are true: (i) the *covered person* has a personal history of breast cancer; (ii) the *covered person* has a personal history of biopsy-proven benign breast disease; (iii) the *covered person's* mother, sister, or daughter has or has had breast cancer; or (iv) the *covered person* has not given birth prior to the age of thirty (30).
2. One (1) baseline breast cancer screening mammography for a *covered person* between the ages of thirty-five (35) and thirty-nine (39) years.
3. A mammogram every other year for any *covered person* between forty (40) and forty-nine (49) years of age, inclusive or more frequently upon recommendation of a *provider*.
4. A mammogram every year for any *covered person* fifty (50) years of age or older.

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

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

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*.
5. Hospital stays for other medically necessary reasons associated with maternity care.

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

1. Give birth in a hospital or other healthcare facility; or
2. Remain under inpatient care in a hospital or other healthcare facility for any fixed term following the bird of a child.

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

Note: This provision does not amend the contract to restrict any terms, limits, or conditions that may otherwise apply to *surrogates* and children born from *surrogates*. Please reference 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 EOC on the bases of fraud, misrepresentation or false information, up to and including recoupment of all benefits that *we* paid on behalf of the *surrogate* during the time that the *surrogate* was insured under *our policy*, plus interest, attorneys' fees, costs and all other remedies available to us.

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

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

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

Prostate Specific Antigen Testing
Covered service expenses include "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for a *covered person* who is at least fifty (50) years of age; and at least once annually for a *covered person* who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

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

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* or outpatient basis to allow temporary relief to family members from the duties of caring for a *covered person* under Hospice Care. Respite days that are applied toward the *deductible amount* are considered benefits provided and shall apply against any maximum benefit limit for these services.

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

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

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

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

are made available at no additional cost to the enrollees. The benefits and services available at any given time are made part of this contract by this reference and are subject to change by us through an update to information available on our website or by contacting us. Social determinants of health benefits and services may be offered to enrollees through the "My Health Pays" wellness program and through local health plan websites. Enrollees may receive notifications about available benefits and services through emails from local health plans and through the "My Health Pays" notification system. To inquire about these benefits and services or other benefits available, you may visit our website at *https://www.ambetterofnorthcarolina.com* or by contacting Member Services at 1-833-863-1310 (Relay 711).

Transplant Expense Benefits
Covered services 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 the 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 enrollee 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 a lapse in coverage due to non-payment of premium, no services related to transplants will be paid as a covered benefit.

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

1. Pre-transplant evaluation
2. Pre-transplant harvesting of the organ from the donor.
3. Left Ventricular Artificial Devices (LVAD)(only when used as a bridge to a heart transplant)
4. Including outpatient *covered services* related to the transplant *surgery*, pre-transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection and other immunosuppressive drug therapy, etc.
5. Pre-transplant stabilization, meaning an *inpatient* stay to *medically stabilize* to prepare for a later transplant, whether or not the transplant occurs.
6. The transplant itself, including the acquisition cost for the organ or bone marrow when authorized through the *Center of Excellence* and services are performed at participating facility.
7. Post-transplant follow-up visits and treatments.
8. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.

9. All costs incurred and medical expenses by the donor; shall be paid under the transplant recipient policy, this excludes travel, lodging, food and mileage. Please see transplant travel expense policy for outlined details on reimbursement limitations (www.Ambetter.com).

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

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

1. *W*e will pay for the following services when the enrollee is required to travel more than 75 miles from the *residence* to the *Center of Excellence*:
2. *We* will pay for the following services:
    a. Transportation for the enrollee, any live donor and the *immediate family* to accompany to and from the *Center of Excellence*, in the United States.
    b. When enrollee and/or donor is utilizing their personal transportation vehicle, a mileage log is required for reimbursement.
    c. Maximum reimbursement for mileage is limited to travel to and from the *member's* home to the transplant facility, and to and from the donor's home to the transplant facility and will be reimbursed at the current IRS mileage standard for miles driven for medical purposes.
    d. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the enrollee while the enrollee is confined in the *Center of Excellence* in the United States. We will 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 enrollee and/or donor.
    f. Please refer to the *member* resources page for *member* reimbursement transplant travel forms and information at www.Ambetter.com.

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these Transplant 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.
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. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("USFDA") regulation, regardless of whether the trial is subject to USFDA oversight.

8. The acquisition cost for the organ or bone marrow, when provided at an un*authorized* facility or not obtained through the *Center of Excellence*.
9. For any transplant services and/or travel related expenses for enrollee and donor, when preformed outside of the United States.
10. The following ancillary items listed below, will not be subject to *member* reimbursement under this *policy*:
    a. Alcohol/tobacco
    b. Car Rental (unless pre-approved by Case Management)
    c. Vehicle Maintenance for motorized and hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, 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.

Urgent Care
Urgent care services include *medically necessary* services by in-*network providers* and services provided at an *urgent care center* including facility costs and supplies. Care that is needed after a *primary care provider's* normal business hours is also considered to be urgent care. *Your* zero *cost sharing* preventive care benefits may not be used at an *urgent care center*.

Members are encouraged to contact their *primary care provider* for an appointment before seeking care from another *provider*, but *network urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *primary care provider* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-833-863-1310 (Relay 711). The 24/7 Nurse Advice Line is available twenty-four (24) hours a day, seven (7) days a week. A registered nurse can help *you* decide the kind of care most appropriate for *your* specific need.

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 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 *https://www.ambetterofnorthcarolina.com* or by contacting Member Services by telephone at 1-833-863-1310 (Relay 711). The benefits are available as long as coverage remains active, unless changed by us as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All enrollees are automatically eligible for program benefits upon obtaining coverage. The programs are optional, and the benefits are made available at no additional cost to the enrollees. The programs and benefits available at any given time are made part of this contract by this reference and are subject to change by us through updates available on our website or by contacting us.

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

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

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

If *you* think *you* could benefit from *our* Care Management program, please call Member Services at 1-833-863-1310 (Relay 711).

General Non-Covered Services and Exclusions

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *member* in the absence of insurance covering the charge.
2. Expenses, fees, taxes, or surcharges imposed on the *member* by a *provider* (including a *hospital*) but that are actually the responsibility of the *provider* to pay.
3. Any services performed by a member of a *member's immediate family.*
4. Any services not identified and included as *covered service expenses* under the *policy*. *You* will be fully responsible for payment for any services that are not *covered service expenses.*

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*, except as expressly provided for under the Benefits after Coverage Terminates clause in this *policy's* Termination section.
2. For any portion of the charges that are in excess of the *eligible service expense.*
3. For the reversal of sterilization and the reversal of vasectomies.
4. For abortion, unless necessary to save the life or health of the *member*, or as a result of incest or rape.
5. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Major Medical Expense Benefits provision.
6. For expenses for television, telephone, or expenses for other persons.
7. For telephone consultations, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
8. For stand-by availability of a *medical practitioner* when no treatment is rendered.
9. For *dental service* expenses*,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits.
10. 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.
11. Mental health services are excluded for:
    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 maintain employment.
12. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
13. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.

14. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *policy)*.
15. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*.
16. 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.
17. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *policy*.
18. For hearing aids, except as expressly provided in this *policy*.
19. 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.
20. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of ninety (90) consecutive days.
21. Services or supplies for the treatment of occupational injury or sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer, or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
22. For or related to surrogate parenting.
23. For or related to treatment of hyperhidrosis (excessive sweating).
24. For fetal reduction surgery.
25. Except as specifically identified as a *covered service expense* under the *policy*, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
26. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or Semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).
27. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
28. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
29. For the following miscellaneous items: Artificial Insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees;

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*.

30. Diagnostic testing, laboratory procedures screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
31. For court ordered testing or care unless *medically necessary*.
32. Surrogacy Arrangement. Health care services, including supplies and medication, to a Surrogate, including a Member acting as a Surrogate or utilizing the services of a Surrogate who may or may not be a Member, and any child born as a result of a Surrogacy Arrangement. This exclusion applies to all health care services, supplies and medication to a Surrogate including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the Surrogate following childbirth);
    d. Mental Health Services related to the Surrogacy Arrangement;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a Surrogacy Arrangement;
    g. Use of frozen gamete or embryos to achieve future conception in a Surrogacy Arrangement;
    h. Preimplantation genetic diagnosis relating to a Surrogacy Arrangement;
    i. Any complications of the child or Surrogate resulting from the pregnancy; or
    j. Any other health care services, supplies and medication relating to a Surrogacy Arrangement.
33. For any medicinal and/or recreational use of cannabis or marijuana.

Any and all health care services, supplies or medication provided to any child birthed by a Surrogate as a result of a Surrogacy Arrangement are also excluded, except where the child is the adoptive child of insureds possessing an active policy with us and/or the child possesses an active policy with us at the time of birth.

Termination

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in 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 the Health Insurance Marketplace, the date of termination that the Health Insurance Marketplace provides *us* upon *your* request of cancellation to the Health Insurance Marketplace;
3. The date *we* decline to renew this *policy,* as stated in the Discontinuance provision;
4. The date of *your* death, if this *policy* is an Individual Plan;
5. The date a *member's* eligibility for coverage under this *policy* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *policy*;
6. The date a *member's* eligibility for coverage under this *policy* ceases as determined by the Health Insurance Marketplace; or
7. For a dependent child reaching the limiting age of 26, coverage under this contract, for a dependent child, will terminate at 11:59 p.m. on the last day of the year in which the dependent child reaches the limiting age of 26.

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

Reinstatement
We will reinstate a *policy* when it is erroneously terminated or cancelled. The reinstatement will result in restoration of the enrollment with no break in coverage.

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

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

Certificate of Creditable Coverage
We will supply a Certificate of *Creditable Coverage* when *you* or *your dependent member's* coverage under this *policy* ends or *you* exhaust continuation of coverage. Keep the Certificate of *Creditable Coverage* in a safe place. *You* may request a Certificate of *Creditable Coverage* from *our* Member Services Department while *you* are still covered under this *policy* and up to 24 months following *your* termination. *You* may call the Member Services Department at 1-833-863-1310 (Relay 711).

Continuity of Care

Termination of Provider: If *you* are undergoing treatment for an *ongoing special condition* at the time the contract between *us* and the *your* treating *provider* is terminated and *you* have filed a claim for services provided by the terminated *provider* or *we* know *you* are a patient of the terminated *provider*, *we* will notify *you* on a timely basis of the termination and of the right to elect continuation of coverage of treatment by the *provider*. *You* will continue to receive treatment up to 90 days after *we* notify *you* of the provider's termination.

Newly Covered Member: If *you* are undergoing treatment from a *provider* for an *ongoing special condition* and are newly covered under this *policy*, *we* will notify *you* on *your* enrollment date of *your* right to elect to continue treatment with the *provider* currently treating *your ongoing special condition*. *You* will continue to receive treatment up to 90 days after *you* enroll in this *policy*.

Transitional Period – Schedule Surgery, Organ Transplantation, or Inpatient Care: If *you* had surgery, organ transplant, or other inpatient care scheduled prior to the *provider* being terminated or *your* recent enrollment in this *policy*, or if *you* were listed on an established waiting list as of the date of notice of *provider* termination or enrollment, *you* will be able to continue to see the *provider* through the date of discharge after completion of the surgery, transplant, or other inpatient care and through post-discharge follow-up care related to the surgery, transplant, or other inpatient care occurring within 90 days after the date of discharge.

Transitional Period – Pregnancy: If *you* are in *your* second trimester of pregnancy when *your provider* was terminated or if *you* are a newly enrolled member, *you* will be able to continue to see the treating *provider* through 60 days of postpartum care.

Transitional Period – Terminal Illness: If *you* were determined to be terminally ill at the time of a *provider's* termination or when *you* enrolled in this *policy* and the *provider* was treating the terminal illness before the date of the termination or enrollment, *you* will be able to continue to see the treating *provider* for the remainder of *your* life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

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. *Ambetter* will send a confirmation to the *member* within 15 days after receiving a notice of claim.

Proof of Loss
We must receive written *proof of loss* within 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 *ambetterofnorthcarolina.com* under "Member Resources". Send all the documentation to *us* at the following address:

Ambetter from North Carolina Health Plan
Attn: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

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

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

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

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

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

Claim payments that are not made within the specified timeframes shall bear interest at the annual percentage rate of eighteen percent (18%) beginning on the date following the day on which the claim should have been paid. If additional information was requested by *us*, interest on claim payments shall begin to accrue on the 31st day after *we* have received the additional information.

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

We may pay all or any part of the benefits provided by this *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*.

Change of Beneficiary
The right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be required to surrender or assignment of this *policy* or to any change of beneficiary or beneficiaries or to any other changes in this *policy*.

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

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

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

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

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

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

Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status, and will be adjudicated by us as set forth in this section. In cases where Medicare or another government program has primary responsibility, Medicare benefits will be taken into account for any *member* who is enrolled for Medicare. This will be done before the benefits under this *health plan* are calculated. When Medicare, Part A and Part B or Part C is primary, Medicare's allowable amount is the highest allowable expense.

When a person is eligible for Medicare benefits and Medicare is deemed to be the primary payer under Medicare secondary payer guidelines and regulations, we will reduce our payment by the Medicare primary payment and pay as secondary up to the Medicare allowable amount. However, under no circumstances will this plan pay more than it would have paid if it had been the primary plan. Charges for services used to satisfy a *member's* Medicare Part B deductible will be applied in the order received by *us*. Two or more expenses for services received at the same time will be applied starting with the largest first.

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

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

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

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

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

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

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

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

1. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions, and limitations of the *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 of Autopsy

We shall have the right and opportunity to examine a *member* while a claim is pending or while a dispute over the claim is pending. These examinations are made at *our* expense and as often as *we* may reasonably require. *Ambetter* shall also have the right to make an autopsy in case of death where it is not forbidden by law.

Legal Actions

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

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.

Appeal and Grievance Procedures

Appeal Procedures

Internal Appeal Procedures: When a health insurance plan denies a request of payment for a treatment or service (a claim for plan benefits, *you* have already received (post-service claim denial) or denies *your* request to authorize treatment or service (prospective claim denial), *you*, or someone *you* have authorized to speak on *your* behalf (an *authorized representative*), can request an *appeal* of the plan's decision. If the plan rescinds *your* coverage or denies *your* application for coverage, *you* may also *appeal* the plan's decision. When *we* receive *your appeal*, *we* are required to review *our* decision. When *we* make an *adverse benefit determination*, *we* are required to notify *you* with:

- The reasons for the decision, including the clinical rationale;
- *Your* right to *appeal* the claim decision;
- Instructions for requesting a written statement of the clinical reviews criteria used;
- *Your* right to request an *external review*; and
- The availability of assistance from The North Carolina Department of Insurance and the Health Insurance Smart NC program, including the telephone number and address of the program.
- If *you* do not speak English, *you* may be entitled to receive *appeals'* information in *your* native language upon request.
- When *you* request an *internal appeal*, *we* must give *you our* decision as soon as possible, but no later than:
    - 72 hours after receiving *your* request when *you* are *appealing* the denial of a claim for urgent care. (If *your appea*l 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 (pre-service denials).
    - 30 days for *appeals* of denials of services, *you* have already received (post-service denials).
    - No extensions of the maximum time limits are permitted unless *you* consent.

Continuing Coverage: *We* cannot terminate *your* benefits until all of the *appeals* have been exhausted. **However, if *our* decision is ultimately upheld, *you* may be responsible for paying any outstanding claims or reimbursing *us* for claim payments 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.

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

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

Ambetter of North Carolina Inc.
Attn: Grievances and Appeals Department
12515-8 Research Blvd., Suite 400

Austin, TX 78759
Fax: 1-833-886-7956
Phone 1-833-863-1310 (Relay 711)

You must file the *appeal* within 180 calendar days of the receipt of the notice of claim denial (an *adverse benefit determination*). Failure to file within this time limit may result in *us* declining to consider the *appeal*. Please include in *your* written *appeal* or be prepared to tell *us* the following:

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

In general, *we* may unilaterally extend the time for providing a decision on post-service claims for 14 calendar days after the expiration of the initial period, if *we* determine that such an extension is necessary for reasons beyond *our* control. There is no provision for extensions in the case of claims involving urgent care.

Non-urgent, pre-service care denial: After *you* file *your* appeal, *we* will notify *you* of all the information that is needed to process the *appeal* within 3 business days of receipt of the *appeal*. For non-urgent *pre-service denials, we* will notify *you* of *our* decision as soon as possible but no later than 30 calendar days of receipt of all the necessary clinical information.

We may extend *our* deadline by no more than 14 calendar days if *we* need additional information to reach a decision. *We* will inform *you* of the request'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 30 calendar days of receipt of *your appeal*.

We must make *our* decision within 48 hours after receipt of the information or at the end of the 44 days, whichever comes first.

Urgent pre-service care denial: ***If your claim for benefits is urgent, you or your authorized representative, or your health care provider (provider) 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, *we* 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.**

Post-service *appeal* of a claim denial (retrospective): If *your appeal* is for a *post-service claim denial*, *we* will notify *you* of *our* decision as soon as possible but no later than 30 calendar days after *we* have received *your appeal*. If *we* need more time to make a decision because *you* have not given *us* necessary information, *you* will have 90 calendar days from the date *we* notify *you* to give *us* the information. *We* will describe the information needed to make *our* decision in the notice *we* send *you*. This is also known as a "retrospective review." *We* will notify *you* of *our* determination as soon as possible but no later than 5 business days after the benefit determination is made.

We must give *you* notice that *your* claim has been denied in whole or in part (paying less than 100% of the claim) before the end of the time allotted for the decision.

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

Rescission of coverage: If *we* rescind *your* coverage, *you* may file an *appeal* according to the following procedures. *We* cannot terminate *your* benefits until all of the *appeals* have been exhausted. Since a rescission means that, no coverage ever existed, if *our* decision to rescind is upheld, *you* will be responsible for payment of all claims for *your* health care services.

***Your* rights to a full and fair review**

- *We* must allow *you* to review the claim file and to present evidence and testimony as part of the internal claims and *appeals* process.
- *We* must provide *you*, free of charge, with any new or additional evidence considered, relied upon, or generated by *us* (or at *our* direction) 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
- Before *we* 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.
- The *adverse benefit determination* must be written in a manner understood by *you*, or if applicable, *your authorized representative* and must include all of the following:

1. The titles and qualifying credentials of the person or persons participating in the review process (the reviewers);
2. Information sufficient to identify the claim involved, including the date of service, the health care provider;
3. A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

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

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

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

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* find that the determination was based on a material misrepresentation about *your* health condition that was knowingly made by *you* or *your provider* of the service, supply, or other item, *we* will 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 *us* must be decided as soon as possible, taking into account the medical urgencies, and notification must be provided to *you* 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 *us* 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 prospective 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.

Availability of Grievance Process: There is a grievance process which allows an *insured person* the opportunity to resolve their grievances. The process is voluntary and is available for the review of any policy, decision or action that affects an *insured person*. The grievance process does not apply to grievances or *appeals* based solely on the basis that the *policy* does not provide or it limits the benefits for the health care service in question, provided the exclusion of the specific service requested is clearly stated in the *policy*.

Grievance Procedures

Call Member Services
Please contact our Member Services team at 1-833-863-1310 (TDD/TYY) 711 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.

Filing a Grievance
The *grievance* review is for standard, non-urgent *grievances*. A *grievance* may be submitted in writing by *you* or your authorized representative acting on your behalf. *You* or *your authorized representative* may file a *grievance* by calling Member Services at 1-833-863-1310 (Relay 711) or in writing by mailing or faxing *your grievance* to:

Ambetter of North Carolina Inc.
Attn: Grievances and Appeals Department
12515-8 Research Blvd., Suite 400
Austin, TX 78759
Fax: 1-833-886-7956
Phone 1-833-863-1310 (Relay 711)

Review of Grievance
Within three (3) business days of receiving a *grievance*, *we* will provide *you* with the name, address, and telephone number of the person coordinating the review and instructions on submitting written material, including the address to which the material may be submitted. *Your* attendance is not permitted for the *grievance* review.

The coordinator is an individual other than the person who initially handled the original matter that is the subject of the *grievance*. If the issue is a clinical one, at least one reviewer must be a medical doctor with appropriate expertise to evaluate the matter under consideration.

We will issue a written decision, in clear terms, to *you* and *your provider*, if applicable, within thirty (30) calendar days after receiving the *grievance*.

The written decision must contain the following information:

- The professional qualifications and licensure of the person or persons reviewing the *grievance*;
- A statement of the reviewers' understanding of the *grievance*;
- The reviewers' decision in clear terms and the contractual or medical rationale in sufficient detail for *you* to respond further to the reviewers' position;
- A reference to the evidence or documentation used as the basis for the decision;
- A statement that the decision is *our* final determination in the matter. If the review concerned a non-certification and the decision is to uphold the initial non-certification, a statement advising *you* of

your right to request an external review once the internal grievance process has been exhausted. The North Carolina notice for external review provides the procedures to follow for requesting an external review and should be provided at this time;

- Notice of the availability to contact the North Carolina Commissioner of Insurance for assistance. The notice should include the following information:

  The North Carolina Department of Insurance
  P.O. Box 26387, Raleigh, NC 27611
  1-800-546-5664; and

- A notice of the availability of assistance from the Health Insurance Smart NC, including the telephone number and address of the program. Services provided by the Health Insurance Smart NC are available through the North Carolina Department of Insurance. To reach this program, contact:

  North Carolina Department of Insurance
  Health Insurance Smart NC
  1201 Mail Service Center
  Raleigh, NC 27699-1201
  (855) 408-1212 (Toll Free)

- Note: A North Carolina licensed M.D. will evaluate all non-certifications.

For a *grievance* concerning the quality of clinical care delivered by *your provider*, *we* will acknowledge the *grievance* within ten (10) business days of receipt of the *grievance*. The acknowledgement must advise *you* that:

1. *We* will refer the *grievance* to its quality assurance committee for review and consideration or any appropriate action against the *provider*; and
2. State law does not allow for a second-level *grievance* review for *grievances* concerning quality of care.

External Review

North Carolina law provides for review of non-certification decisions by an external, *Independent Review Organization* (IRO). An *Independent Review Organization* is an entity that conducts independent external reviews of appeals of non-certifications and second-level grievance review decisions.

The North Carolina Department of Insurance (NCDOI) administers this service at no charge to *you*, arranging for an IRO to review *your* case once the NCDOI establishes that *your* request is complete and eligible for review. *You* or someone *you* have authorized to represent *you* may request an external review. *We* will notify *you* in writing of *your* right to request an external review each time *you*:

- Receive a non-certification decision; or
- Receive an *appeal* decision upholding a non-certification decision.

In order for *your* request to be eligible for external review, the NCDOI must determine the following:

- That *your* request is about a medical necessity determination that resulted in a non-certification decision;
- That *you* had coverage with *us* in effect when the non-certification decision was issued;
- That the service for which the non-certification was issued appears to be a *covered service* under *your policy*; and
- That *you* have exhausted *our* internal review process.

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

Standard External Review
For a standard external review, *you* will be considered to have exhausted the internal review process if *you* have:

- Completed *our appeal* and *grievance* review and received a written determination from *us*; or
- Received notification that *we* have agreed to waive the requirement to exhaust the internal *appeal* and/or *grievance* process.

If *your* request for a standard external review is related to a retrospective non-certification (a non-certification which occurs after *you* have received the services in question), *you* will not be eligible to request a standard review until *you* have completed *our* internal review process and received a written final determination from *us.*

If *you* wish to request a standard external review, *you* (or *your* representative) must make this request to NCDOI within 120 calendar days of receiving written notice from *us* of final determination that the services in question are not approved. When processing *your* request for external review, the NCDOI will require *you* to provide the NCDOI with a written, signed authorization for the release of any of *your* medical records that may need to be reviewed for the purpose of reaching a decision on the external review.

Within 10 business days of receipt of *your* request for a standard external review, the NCDOI will notify *you* and *your provider* of whether *your* request is complete and whether it is accepted. If the NCDOI notifies *you* that *your* request is incomplete, *you* must provide all requested additional information to the NCDOI within 150 calendar days of the date of *our* written notice of final determination. If the NCDOI accepts *your* request, the acceptance notice will include:

- The name and contact information for the Independent Review Organization (IRO) assigned to *your* case;
- A copy of the information about *your* case that *we* have provided to the NCDOI;
- Notification that *we* will provide *you* or *your authorized representative* with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO); and
- Notification that *you* may submit additional written information and supporting documentation relevant to the initial non-certification to the assigned IRO within seven (7) days of the date of the acceptance notice.

Upon NCDOI's request, *we* will, within three (3) business days, provide all information required for the Commissioner to conduct a preliminary review to determine whether:

- *You* are or were a *covered person* in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a *covered person* in the health benefit plan at the time the health care service was provided.
- The health care service that is the subject of the non-certification *appeal* decision or the second-level *grievance* review decision upholding a non-certification reasonably appears to be a *covered service* under the health benefit plan.
- *You* have exhausted *our* internal *appeal* and *grievance* processes under G.S. 58-50-61 and G.S. 58-50-62, unless *you* are considered to have exhausted *our* internal *appeal* or *grievance* process under G.S. 58-50-79, or unless *you* have waived *your* right to conduct an expedited review of the *appeal* decision.
- You have provided all the information and forms required by the Commissioner that are necessary to process an external review.

If *you* choose to provide any additional information to the IRO, *you* must also provide that same information to *us* at the same time using the same means of communication (e.g., *you* must fax the information to *us*. if *you* faxed it to the IRO). When faxing information to *us*, send it to 1-833-886-7956. If *you* choose to mail *your* information, send it to:

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

Please note that *you* may also provide this additional information to the NCDOI within the 7 calendar day deadline rather than sending it directly to the IRO and *us*. The NCDOI will forward this information to the IRO and *us* within two business days of receiving *your* additional information.

The IRO shall review all of the information and documents that have been forwarded to the organization by the Commissioner and the insurer. In addition, the assigned review organization, to the extent the documents or information are available, shall consider the following in reaching a decision:

- The covered person's medical records.
- The attending health care provider's recommendation.
- Consulting reports from appropriate health care providers and other documents submitted by the insurer, covered person, or the covered person's treating provider.
- The most appropriate practice guidelines that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy.
- Any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization.
- Medical necessity, as defined in G.S. 58-3-200(b) .
- Any documentation supporting the medical necessity and appropriateness of the provider's recommendation.

The IRO will send *you* written notice of its determination within 45 calendar days of the date the NCDOI received *your* standard external review request. If the IRO's decision is to reverse the non-certification, *we* will, reverse the non-certification decision within 3 business days of receiving notice of the IRO's decision, and provide coverage for the requested service or supply that was the subject of the non-certification decision. If *you* are no longer covered by *us* at the time *we* receive notice of the IRO's decision to reverse the non-certification, *we* will only provide coverage for those services or supplies *you* actually received or would have received prior to disenrollment if the service had not been non-certified when first requested.

Expedited External Review
An expedited external review of a non-certification decision may be available if *you* have a medical condition where the time required to complete either an expedited internal *appeal* or *grievance* review or a standard external review would reasonably be expected to seriously jeopardize *your* life or health or would jeopardize *your* ability to regain maximum function. If *you* meet this requirement, *you* may make a written request to the NCDOI for an expedited review after *you*:

- Receive a non-certification decision from *us* AND file a request with *us* for an expedited *appeal*; or
- Receive a *grievance* review decision upholding the original non-certification.

You may also make a request for an expedited external review if *you* receive an adverse *grievance* review decision concerning a non-certification of an admission, availability of care, continued stay or emergency care, but have not been discharged from the inpatient facility.

In consultation with a medical professional, the NCDOI will review *your* request and determine whether it qualifies for expedited review. *You* and *your provider* will be notified within 2 calendar days if *your* request is accepted for expedited external review. If *your* request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard external review if *our* internal review process was already completed, or (2) require the completion of *our* internal review process before *you* may make another request for an

external review with the NCDOI. An expedited external review is not available for retrospective non-certifications.

Within two (2) calendar days after receiving a request for an expedited external review, the Commissioner shall complete all of the following:

(1) Notify the insurer that made the non-certification, non-certification appeal decision, or second-level grievance review decision which is the subject of the request that the request has been received and provide a copy of the request. The Commissioner shall also request any information from the insurer necessary to make the preliminary review set forth in G.S. 58-50-80(b)(2) and require the insurer to deliver the information not later than one day after the request was made.

(2) Determine whether the request is eligible for external review.

(3) If the request is eligible for external review and the covered person's treating provider requesting the service that is the subject of the external review has certified the request on a form prescribed by the Commissioner, then one of the following shall apply:

a. For a request made pursuant to subdivision (a)(1) of this section, the request shall be reviewed on an expedited basis because the time frame for completion of an expedited review under G.S. 58-50-61(l) would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall inform the covered person, the covered person's provider who performed or requested the service, and the insurer whether the Commissioner has accepted the covered person's request for an expedited external review. If the Commissioner has accepted the covered person's request for an expedited external review, then the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame. If the Commissioner has not accepted the covered person's request for an expedited external review, then the covered person shall be notified.
b. For a request made pursuant to subdivision (a)(2) of this section, the request shall be reviewed on an expedited basis because the time frame for completion of an expedited review under G.S. 58-50-62 would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall inform the covered person, the covered person's provider who performed or requested the service, and the insurer whether the Commissioner has accepted the covered person's request for an expedited external review. If the Commissioner has accepted the covered person's request for an expedited external review, then the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame. If the Commissioner has not accepted the covered person's request for an expedited external review, then the covered person shall be notified.
c. For a request made pursuant to sub-subdivision (a)(3)a. of this section, the request shall be reviewed on an expedited basis because the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall inform the covered person, the covered person's provider who performed or requested the service, and the insurer whether the review will be conducted using an expedited or standard time frame and shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame.
d. For a request made pursuant to sub subdivision (a)(3)b. of this section, the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the expedited review and inform the covered person, the covered person's provider who performed or requested the service, and the insurer of its decision.

The IRO will communicate its decision to uphold or reverse the non-certification to *you* within 3 calendar days or as expeditiously as the covered person's medical condition or circumstances require from the date the NCDOI received *your* request for an expedited external review. If the IRO's decision is to reverse the non-certification, *we* will, within one day of receiving notice of the IRO's decision, reverse the non-certification decision for the requested service or supply that is the subject of the non-certification decision. If *you* are no longer covered by *us* at the time *we* receive notice of the IRO's decision to reverse the non-certification, *we* will only provide coverage for those services or supplies *you* actually received or would have received prior to disenrollment if the service had not been non-certified when first requested.

The IRO's external review decision is binding on *us* and *you*, except to the extent *you* may have other remedies available under applicable federal or state law. *You* may not file a subsequent request for an external review involving the same non-certification decision for which *you* have already received an external review decision.

For further information about external review or to request an external review, contact the NCDOI at:
By Mail: NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
(Fax) 919-807-6865

In Person: NC Department of Insurance
Albemarle Building
325 N. Salisbury St.
Raleigh, NC
Toll-free telephone number 855-408-1212
www.ncdoi.com/smart

The Health Insurance Smart NC Program is also available to provide assistance to consumers who wish to file an *appeal* or *grievance* with their health plan.

Department of Insurance Complaints
The North Carolina Department of Insurance is available to assist insurance consumers with insurance related problems and questions. *You* may inquire in writing to the Department at PO Box 26387, Raleigh, NC, 27611 or by telephone at 1-800-546-5664.

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard Grievance	180 Calendar Days	3 Business Days	30 Calendar Days	N/A
Standard Pre-Service Appeal	180 Calendar Days	3 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	3 Business Days	30 Calendar days	14 Calendar Days

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
External Review	120 Calendar Days	N/A	45 Calendar Days	N/A
Expedited External Review	120 Calendar Days	N/A	72 Hours	N/A

General Provisions

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

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

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

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

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

You will be provided 30 days' notice of a rescission.

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

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

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

We protect all oral, written and electronic PHI. *We* follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. *We* are required to notify *you* about these practices every year. This notice describes how *your* medical information may be used and disclosed and how *you* can get access to this information. Please review it carefully. If *you* need more information or would like the complete notice, please visit https://www.ambetterofnorthcarolina.com/privacy-practices.html or call Member Services at 1-833-863-1310 (Relay 711).

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

Language
If *you* do not speak or understand the language in *your* area, *you* have the right to an interpreter. For language assistance, please visit: https:// www.ambetterofnorthcarolina.com /language-assistance.html.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de North Carolina, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-863-1310 (Relay 711).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter of North Carolina 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-833-863-1310 (Relay 711).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter of North Carolina, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-833-863-1310 (Relay 711).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter of North Carolina 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-833-863-1310 (Relay 711). 로 전화하십시오.
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter of North Carolina, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-833-863-1310 (Relay 711).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter of North Carolina ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل 1-833-863-1310 (Relay 711).
Hmong:	Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Ambetter of North Carolina, 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 1-833-863-1310 (Relay 711).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter of North Carolina вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-833-863-1310 (Relay 711).
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter of North Carolina, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-833-863-1310 (Relay 711).
Gujarati:	જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter of North Carolina વિશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-833-863-1310 (Relay 711) ઉપર કૉલ કરો.
Mon-Khmer, Cambodian:	ប្រសិនលោកអ្នកឬ នរណាម្នាក់ដែលអ្នកកំពុងជួយមានសំណួរអំពី Ambetter of North Carolina អ្នកមានសិទ្ធិទទួលបានជំនួយនិងព័ត៌មានជាភាសារបស់លោកអ្នកដោយឥតគិតថ្លៃ។ សូមនិយាយទៅកាន់អ្នកបកប្រែភាសាសូម 1-833-863-1310 (Relay 711).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from North Carolina hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-833-863-1310 (Relay 711) an.
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter of North Carolina के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-833-863-1310 (Relay 711).पर कॉल करें।
Laotian:	ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ Ambetter of North Carolina, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ ໃຫ້ໂທຫາ 1-833-863-1310 (Relay 711).
Japanese:	Ambetter of North Carolina について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-833-863-1310 (Relay 711). までお電話ください。

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Member Services Department: 1-833-863-1310 (Relay 711)
Log on to: www.ambetterofnorthcarolina.com

Statement of Non-Discrimination

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

Ambetter of North Carolina Inc.:

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

If you need these services, contact Ambetter of North Carolina Inc. at 1-833-863-1310 (Relay 711).

If you believe that Ambetter of North Carolina Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ambetter of North Carolina Inc., ATTN: Ambetter Grievances and Appeals Department, 12515-8 Research Blvd., Suite 400, Austin, TX 78759, 1-833-863-1310 (Relay 711), Fax 1-833-886-7956. You can file a grievance by mail or fax. If you need help filing a grievance, Ambetter of North Carolina Inc. 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*.

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