ambetter. FROM absolute total care

2021 Evidence of Coverage

Ambetter.AbsoluteTotalCare.com

79222SC002-2021

Ambetter from Absolute Total Care

Home Office: 1441 Main St., #900, Columbia, SC 29201

Major Medical Expense Insurance Policy

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 Absolute Total Care.

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 the *policy* terms. *You* may keep this *policy* (or the new *policy you* are mapped to for the following year) in effect 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 covered services.

In addition to the above, this guarantee for continuity of coverage shall not prevent *us* from cancelling or non-renewing this *policy* in the following events: (1) non-payment of premium; (2) a *member* is found to be in material breach of this policy; or (3) a change in federal or state law no longer permits the continued offering of such coverage, such as Centers for Medicare and Medicaid Services ("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.

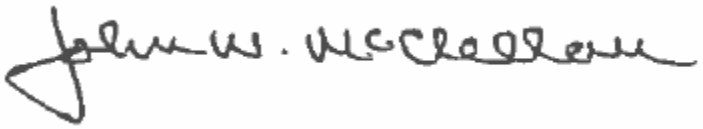
At least 31 days' notice of any plan to take an action or make a change permitted in accordance with this *policy* will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *policy* or a change in a *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.

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*. 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*.

Absolute Total Care



John McClellan

Health Plan President & CEO

TABLES OF CONTENTS

Introduction 5
Member Rights and Responsibilities 6
Important Information 9
Definitions 11
Dependent Member Coverage 27
Ongoing Eligibility 29
Premiums 32
Prior Authorization 34
Cost Sharing Features 36
Access to Care 38
Major Medical Expense Benefits 40
- Ambulance Service Benefits 40
- Autism Spectrum Disorder Benefits 40
- Diabetic Care 42
- Dialysis Services 42
- Durable Medical Equipment, Prosthetics, and Orthotic Devices 43
- Habilitation, Rehabilitation, and Skilled Nursing Facility Expense Benefits 46
- Home Health Care Service Expense Benefits 46
- Hospice Care Service Expense Benefits 47
- Hospital Benefits 47
- Medical and Surgical Expense Benefits 48
- Mental Health and Substance Use Disorder Benefits 49
- Other Dental Services 50
- Outpatient Medical Supplies Expense Benefits 50
- Pediatric Vision Expense Benefits 50
- Prescription Drug Expense Benefits 51
- Preventive Care Expense Benefits 54
- Respite Care Expense Benefits 58
- Second Medical Opinion 58
- Transplant Expense Benefits 59
- Urgent Care 59

General Non-Covered Services and Exclusions 62
Termination 65
Right of Reimbursement 67
Claims 69

Grievance and Complaint Procedures 74
General Provisions 81

Introduction

Welcome to Ambetter from Absolute Total Care! This *policy* is a Health Maintenance Organization (**HMO**) from Ambetter from Absolute Total Care*. 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 the 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
Absolute Total Care
1441 Main St.
Suite 900
Columbia, SC 29201

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST
Member Services **1-833-270-5443**
TDD/TTY line **711**
Fax **1-833-719-7815**
Emergency **911**
24/7 Nurse Advice Line **1-833-270-5443**

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

Our interpreter services are provided at no cost to *you*. *We* have representatives that speak Spanish and 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, call Member Services at 1-833-270-5443 or for the hearing impaired (TDD/TTY 711).

Member Rights and Responsibilities

We are committed to:

1. Recognizing and respecting *you* as a *member*.
2. Encouraging open discussions between *you*, *your physician,* and *medical practitioners*.
3. Providing information to help *you* become an informed 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, expected health or genetic status, or *health status-related factors*.

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 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 physician* 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 *physicians* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care provider* about what might be wrong (to the level known), treatment and any known likely results. *Your primary care provider* can tell *you* about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for *your* approval for treatment unless there is an *emergency* and *your* life and health are in serious danger.
8. Make recommendations regarding *member's* rights, responsibilities, and policies.
9. Voice *complaints* or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. See *your* medical records.
11. 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.
12. A current list of *network providers*.
13. Select a health plan or switch health plans, within the guidelines, without any threats or

harassment.

14. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin, or religion.
15. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
16. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
17. 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.
18. 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.
19. Know the name and job title of people giving *you* care. *You* also have the right to know which *physician* is *your primary care provider*.
20. An interpreter when *you* do not speak or understand the language of the area.
21. A second opinion by a *network provider*, at no cost to *you*, if *you* want more information about *your* treatment or would like to explore additional treatment options.
22. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it.
23. 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 physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* ID card and keep scheduled appointments with *your physician*, and call the *physician's* office during office hours whenever possible if *you* have a delay or cancellation.
6. Know the name of *your* assigned *primary care provider*. *You* should establish a relationship with *your physician*. *You* may change *your primary care provider* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* 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 *physician*.
11. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care provider* to develop treatment

goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.

12. Follow all health benefit plan guidelines, provisions, policies, and procedures.
13. Use any emergency room only when *you* think *you* have a medical *emergency*. For all other care, *you* should call *your primary care provider*.
14. 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 us.
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 us if *you* have any changes to *your* name, address, or family members covered under this *policy* within 60 days from the date of the event.

Important Information

Provider Directory
A listing of *network providers* is available online at ambetter.absolutetotalcare.com. *We* have plan *physicians*, *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, specialty and board certifications.

At any time, *you* can request a copy of the provider directory at no charge by calling Member Services at 1-833-270-5443 (TTY 711). In order to obtain benefits, *you* must designate a *network 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 1-833-270-5443 (TTY 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 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 1-833-270-5443 (TTY 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 ambetter.absolutetotalcare.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 *PCP*.

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 physician* or service provided by *us*, please contact the Member Services Department.

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

Definitions

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

Wherever used in this *policy*:

Acute rehabilitation 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 a refundable credit when *you* file *your* federal income tax return. If *your advanced premium tax credits* for the year are more than the total amount of *your* premium tax credit, *you* must repay the excess *advanced premium tax credit* with *your* tax return.

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

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

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

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

Appeal means a request for a Plan to reconsider a previous decision regarding an adverse benefit determination, including adverse medical necessity and benefit decisions. A member or authorized representative of a member may appeal any adverse decision. There may be several levels of appeal and the appeal process may be conducted internally or externally or both as required by State/Federal regulations.

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

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

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

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

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

Center of excellence means a *hospital* that:
1. Specializes in a specific type or types of *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*.

Claimant means a covered person or his or her authorized representative.

Clinically urgent grievance means a grievance where any of the following applies:
1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the claimant or the ability of the claimant to regain maximum function.
2. In the opinion of a physician with knowledge of the claimant's medical condition, the claimant is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.

3. A physician with knowledge of the claimant's medical condition determines that the grievance shall be treated as a clinically urgent grievance.

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

Complaint means any expression of dissatisfaction expressed to *us* by *you*, or a claimant's authorized representative, about us or the *providers* with whom we have a direct or indirect contract.

Complications of pregnancy means:

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

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

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

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

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

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

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

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

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

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

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

Deductible amount or ***Deductible*** means the amount that *you* must pay in a *calendar year* for *covered service expenses* before *we* will pay benefits (other than preventive health benefits as discussed under the Preventive Care Expense Health Provision). 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 his or her individual the *deductible* until his or her individual deductible or 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. Examples include, but are not limited to, wheelchairs, crutches, hospital beds, and oxygen equipment.

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 prior to reaching age 18;
4. A child for whom legal guardianship has been awarded to *you* or *your spouse*; or
5. A stepchild.

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

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

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

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

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

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

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

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

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.

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 as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the inpatient setting is appropriate, and if appropriate, the number of days considered *medically necessary*. By contacting us, you may avoid financial responsibility for any inpatient care that is determined to be not *medically necessary* under your Plan. If your provider does not contract with us, you will be financially responsible for any care we determine is not *medically necessary*. Care and treatment provided once you are medically stabilized is no longer considered emergency care. Continuation of care from a non-participating provider beyond that needed to evaluate or stabilize your condition in an emergency will be covered as a non-network service unless we authorize the continuation of care and it is *medically necessary*.

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.

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 *FDA* oversight.
2. An *unproven service.*
3. Subject to *FDA* approval, and:
    a. It does not have *FDA* approval;
    b. It has *FDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has *FDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *FDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services (HHS);

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*.

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

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*.

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

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

Habilitation or ***habilitation services*** means healthcare services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

Health status-related factors mean any of the following factors:

1. Health status;
2. Medical condition, including both physical and mental illnesses and behaviors related to health status;
3. Claims experience;
4. Receipt of health or behavioral health care;
5. Medical history;
6. Genetic information;
7. Evidence of insurability, including contributions arising out of acts of domestic violence; and

8. Disability.

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 *physician*.

Home health care agency means a public or private agency, or one of its subdivisions, that:
1. Operates pursuant to law as a *home health care agency*;
2. Is regularly engaged in providing *home health care* under the regular supervision of a registered nurse;
3. Maintains a daily medical record on each patient; and
4. Provides each patient with a planned program of observation and treatment by a *physician,* in accordance with existing *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 *physician* 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 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*.

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

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

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.

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

Inpatient means that services, supplies, or treatment for medical, behavioral health, or *substance use disorders* 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.

Maternity services includes prenatal care, perinatal care, and childbirth.

Maximum out-of-pocket amount is the sum of the *deductible amount*, *prescription drug deductible amount* (if applicable), *copayment amount,* and *coinsurance* percentage of *covered expenses*, as shown in the *Schedule of Benefits*. After the *maximum out-of-pocket amount* is met for an individual, Ambetter from Absolute Total Care 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 or skills and functioning for daily living can be expected, even though there may be fluctuations in levels of pain and function.

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

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

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

Charges incurred for medical services, supplies, or treatment that are 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 policyholder.

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

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, providers, and facilities* who have contracts with us that include an agreed upon price for health care services or expenses.

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

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

Non-elective caesarean section means:

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

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

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

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

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

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

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 on 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 that has already been provided.

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

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

Prescription 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 *physician* or each *authorized* refill or such requests.

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

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

Primary care provider 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 the policy. 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 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, and birth abnormalities, 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 on an *inpatient basis*.

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

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

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

Rescission of a policy means a determination by us 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 South Carolina to sell and market *our* health plans. This is where the majority of *our* participating *providers* are located where *you* will receive *your* health care services and supplies. *You* can receive precise *service area* boundaries from *our* website or *our* Member Services department.

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

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

Spouse means the person to whom you are lawfully married.

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 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 *physician* 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 has a fertilized egg placed in her body but the egg is not her own.

Surveillance tests for ovarian cancer means annual screening using:
1. CA-125 serum tumor marker testing;
2. Transvaginal ultrasound; or
3. Pelvic examination.

Telehealth services means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the provider for telehealth is at a distant site. Telehealth services includes synchronous interactions and asynchronous store and forward transfers.

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 *physician* 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.

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

Tobacco *or* ***nicotine*** *use* or *use of* ***tobacco*** *or nicotine* means *use of tobacco or nicotine* by individuals who legally use *or nicotine or tobacco* under federal and state law on average four or more times per week (or used *tobacco or nicotine* within 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.

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

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

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

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

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

Dependent Member Coverage

Dependent Member Eligibility

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

1. The date *you* became covered under this *policy;*
2. The date of marriage to add a *spouse or stepchild*;
3. The date of an eligible newborn's birth; or
4. The date that an adopted child is placed with *you* or *your spouse* for the purposes of adoption or *you* or *your spouse* assumes total or partial financial support of the child.
5. We do not deny enrollment of a child under the health plan of the child's parent on the grounds that the child:

    1. Was born out of wedlock;
    2. Is not claimed as a dependent on the parent's federal tax return; or
    3. Does not reside with the parent or within our service area.

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 a family member will be covered from the time of birth until the 31st day after its birth. To provide additional coverage, you must contact the entity that you initially enrolled for coverage through (either the Health Insurance Marketplace or us) and add the *eligible child* as a dependent. 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 retroactively to the 31st day after its birth, unless *we* have received notice by the Health Insurance Marketplace of the child's birth by the 60th day after his or her birth.

Coverage for an Adopted Child

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

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

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate retroactively to the 31st day following *placement*, unless *we* have received both: (A) *n*otification 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 the earlier of:

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

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

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 policy , 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 policy or the date that *we* have not received timely premium payments in accordance with the terms of this policy ;
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 at www.healthcare.gov or 1-800-318-2596. If you enrolled through Ambetter contact 1-833-270-5443 (TTY 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 member turns 26 years of age unless otherwise outlined below.

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

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

Upon reaching the limiting age, a former dependent *eligible child* may be issued a policy providing coverage which is most nearly similar to, but not greater than the coverage under which they were formerly covered, if they apply for such coverage within 30 days following the attainment of the limiting age and pay all required premiums. Any probationary or waiting period must be considered met to the extent coverage was in force under this *policy*.

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* experiences a *loss* of *minimum essential coverage,* non-calendar year group or individual health insurance coverage, pregnancy-related coverage, access to

healthcare services through coverage provided to a pregnant enrollee's unborn child, or medically needed coverage;

2. A *qualified individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order;
    a. In the case of marriage, at least one spouse must demonstrate having minimum essential coverage as described in 26 CFR 1.5000A-1(b) for one 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 one or more 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;
    a. The qualifying events for employees are:
        i. Voluntary or involuntary termination of employment for reasons other than gross misconduct; or
        ii. Reduction in the number of hours of employment.
    b. The qualifying events for *spouses* are:
        i. Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct;
        ii. Reduction in the hours worked by the covered employee;
        iii. Covered employee's becoming entitled to Medicare;
        iv. Divorce or legal separation of the covered employee; or
        v. Death of the covered employee.
    c. The qualifying events for dependent children are the same as for the *spouse* with one addition:
        i. Loss of dependent child status under the plan rules.
10. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a *qualified health plan* or change from one *qualified health plan* to another one time per month;
11. A *qualified individual* or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide.
12. A qualified individual or dependent is a victim of domestic abuse or spousal abandonment and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;

13. A qualified individual or dependent is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 days after the qualifying event;
14. A qualified individual newly gains access to an employer sponsored individual coverage HRA or a Qualified Small Employer Health Reimbursement Arrangement (HRA); or
15. 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.

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.

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 two (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 three (3) months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period.
>
> *We* will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period, and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. *We* will notify HHS of the non-payment of premiums, and will notify 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 his or her grace period as described above.

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, and will notify the *member*, as well as *providers* of the possibility of denied claims when the *member* is in the grace period.

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. During the time the member is uninsured, they will be responsible for paying any medical bills incurred.

Third Party Payment of Premiums or Cost Sharing
Ambetter require each *member* to pay his or her premiums and this is communicated on *your* monthly billing statements. Our 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 your premiums on *your* behalf:

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

Upon discovery that premiums were paid by a person or entity other than those listed above, *we* will reject the payment and inform the *member* that the payment was not accepted and that the 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 accidently 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* or rescind *your* coverage 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 medical and behavioral health *covered service expenses* require *prior authorization*. In general, *network providers* must obtain authorization from *us* prior to providing a service or supply to a *member.* However, there are some *network eligible service expenses* for which *you* must obtain the *prior authorization*.

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

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

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

1. At least five (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.
5. At least five (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/or your *provider* if the request has been *approved* as follows:

1. For immediate request situations, within one (1) business day, when the lack of treatment may result in an emergency room visit or *emergency* admission.
2. For urgent concurrent reviews within 24 hours of receipt of the request.
3. For urgent *pre-service* reviews, within 72 hours from date of receipt of the request.
4. For non-urgent *pre-service* or retrospective reviews within five (5) days, but no longer than 14 days, of receipt of the request.
5. For post-service requests, within 30 calendar days of receipt of the request.

How to Obtain Prior Authorization

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

Failure to Obtain Prior Authorization

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

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

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

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

Prior Authorization Denials
Refer to the Appeal and Grievance Procedures section of this *contract* for information on *your* right to *appeal* a denied authorization.

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

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

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

Services from Non-Network Providers
Except for *emergency* medical services, *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 a *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.

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

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

Cost Sharing Features

Cost Sharing Features

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

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

Copayments

A *copayment* is typically a fixed amount due at the time of service. *Members* may be required to pay *copayments* to a *provider* each time services are performed that require a *copayment*. *Copayments* are due as shown in the *Schedule of Benefits*. Payment of a *copayment* does not exclude the possibility of a *provider* billing you for any non-*covered 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. *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% paid by *you*.

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*.

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 amount*.

Access to Care

Primary Care Provider

In order to obtain benefits, *you* must designate a *network primary care provider* for each *member. If you do not select a network primary care provider for each member, one will be assigned. You* may select any *network primary care provider* who is accepting new patients or 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 or by contacting *our* Member Services department.

Your network primary care provider will be responsible for coordinating all covered health services with other *network providers. You* do not need a referral from *your network primary care provider* for mental or behavioral health services, obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist. *You* do need a referral from *your network primary care provider* to see a *network* dermatologist, but once *you* have such a referral, *you* may see that dermatologist without needing further referrals until the earlier of six (6) months or four (4) visits, provided, however, that such visits are related to the issue for which the original referral was made or related complications. In addition, *your network primary care provider* may make annual referrals for you to see a *network* dermatologist if *you* have a past history of malignant melanoma.

Changing Your Primary Care Physician (PCP)

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

Contacting Your Primary Care Physician

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

Should you need care outside of your PCP's office hours, you should call your PCP's office for information on receiving after hours care in your area. If you have an urgent medical problem or question or cannot reach your PCP during normal office hours, call our 24/7 nurse advice line at 1-833-270-5443 (TTY/TDD 711). A licensed nurse is always available and ready to answer your health questions. In an emergency, call 911 or head straight to the nearest emergency room.

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.

Continuation of Care
In the event your network provider is terminated from the network for any reason, continuation of care for a period up to 90 days or until the termination of the benefit period, whichever is great, will be provided for members who have a serious medical condition, such as a disability, cancer, acute myocardial infarction, or pregnancy.

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 South 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 South 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 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 members. Some services require *prior authorization*. Services should always be provided in the least restrictive clinically appropriate setting.

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*, including, but not limited to, specific benefit, day or visit limits. *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. We 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*.

Benefits for air ambulance services are limited to:

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

Exclusions:

No benefits will be paid for:

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

Autism Spectrum Disorder Benefits

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

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

- evaluation and assessment services;
- *applied behavior analysis therapy;*
- behavior training and behavior management;

- speech therapy;
- occupational therapy;
- physical therapy;
- *psychiatric care such as counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor or clinical social worker; and*
- medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

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

Dental Benefits – Adults 19 years of age or older

Coverage for dental services is provided for adults, age 19 and older, for Preventive and Diagnostic, Minor Restorative and Major Restorative from a *network provider.*

1. Preventive and Diagnostic (Routine Dental Services)—Class 1 benefits include:
   a. Routine cleanings;
   b. Oral exams;
   c. X-rays – bite-wing, full-mouth and panoramic film;
   d. Topical fluoride application.
2. Minor Restorative (Basic Dental Care)— Class 2 benefits include:
   a. Minor restorative – metal and resin based filings;
   b. Endodontic therapy;
   c. Periodontics – scaling, root planning and periodontal maintenance;
   d. Simple extractions;
   e. Prosthodontics – relines, rebase, adjustment and repairs.
3. Major Restorative (Major Dental Care)—Class 3 benefits include:
   a. Crowns and bridges;
   b. Dentures;
   c. More complex extractions and surgical services.

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

Services not covered:

1. Out of network services;
2. *Dental services* that are not necessary or specifically covered;
3. Hospitalization or other facility charges;
4. *Prescription drugs* dispensed in the dental office;
5. Any dental procedure performed solely as a cosmetic procedure;
6. Charges for dental procedures completed prior to the *member*'s *effective date* of coverage;
7. Anesthesiologists services;
8. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (wear), realignment of teeth, periodontal splinting, and gnathologic recordings;
9. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles;

10. Any artificial material implanted or grafted into soft tissue, surgical removal of implants, and implant services;
11. Sinus augmentation;
12. Surgical appliance removal;
13. Intraoral placement of a fixation device;
14. Oral hygiene instruction, *tobacco* or *nicotine* counseling, nutritional counseling;
15. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture;
16. Any oral surgery that includes surgical endodontics (apicoectomy and retrograde filling);
17. Analgesia (nitrous oxide);
18. Removable unilateral dentures;
19. Temporary procedures;
20. Splinting;
21. Temporal Mandibular Joint disorder (TMJ) appliances, therapy, films and arthorograms;
22. Tests and examinations;
23. Oral pathology laboratory;
24. Consultations by the treating provider and office visits;
25. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
26. Veneers (bonding of coverings to the teeth);
27. Orthodontic treatment procedures;
28. Orthognathic surgery;
29. Athletic mouth guards; and
30. Space maintainers.

Diabetic Care

For *medically necessary* services and supplies used in the treatment and management of diabetes where such supplies are prescribed by a provider who demonstrates adherence to minimum standards of care for diabetes as adopted and published by the Diabetes Initiative of Mammography South Carolina *Covered service expenses* include, but are not limited to, exams including podiatric exams; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine or ketone strips, blood glucose monitors (including non-invasive monitors and monitors for the blind) and 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. Diabetes self-management training and education will be provided on an outpatient basis when done by a registered or licensed health care professional that is certified in diabetes.

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 expenses 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 that 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.

<u>Durable Medical Equipment</u>

The rental (or, at *our* option, the purchase) of *durable medical equipment* prescribed by a *physician* or other *provider*. 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 costs of 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; if the equipment is owned by the *member*; medically fitting supplies may be paid separately.

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.

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 generally included. Applicable tax, shipping, postage, and handling charges are also covered. Note that casting is covered when an orthotic appliance is billed with it, but not if billed separately.

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

8. Built-up shoe.
9. Custom made shoe inserts.

Orthotic *devices* 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 *orthotic device* is damaged and cannot be repaired.

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

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

Exclusions:

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

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

Habilitation, Rehabilitation, and Skilled Nursing Facility Expense Benefits

Covered service expenses include services provided or expenses incurred for *habilitation* or *rehabilitation* services 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 three (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 *physician*, filled by a licensed pharmacist, and approved by the FDA, unless such drugs or medicines are "off-label drugs" as described under the Prescription Drug Expense Benefits heading.
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners.*
5. Outpatient physical therapy, occupational therapy, and physical therapy.

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. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
3. I.V. medication and pain medication.
4. Hemodialysis, and for the processing and administration of blood or blood components.
5. *Necessary medical supplies*.
6. Rental of *medically necessary durable medical equipment*.
7. Sleep studies.

Charges under (3) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

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

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

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

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

1. Room and board in a *hospice* while the *member* is an *inpatient.*
2. Occupational therapy.
3. Speech-language therapy.
4. The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *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 Hospice Care Service Expense Benefits provision.

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

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

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

Medical and Surgical Expense Benefits

Medical *covered services* and supplies are limited to charges:

1. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies.
2. Made by a *physician* 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, ultrasonography, 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 the hospitalization for mastectomies, coverage will be provided for at least forty-eight (48) hours following a mastectomy. In the case of an early release, coverage shall include at least one home care visit if ordered by the attending physician.
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.
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. *Covered service expenses* are subject to all other terms and conditions of the *policy,* including the *deductible amount* and *percentage* provisions.
14. For the following types of tissue transplants:
    1. Cornea transplants.
    2. Artery or vein grafts.
    3. Heart valve grafts.
    4. Prosthetic tissue replacement, including joint replacements.
    5. Implantable prosthetic lenses, in connection with cataracts.
15. Family planning for certain professional *provider* contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.
16. *Medically necessary services* made by a *physician* in an *urgent care center*, including facility costs and supplies.
17. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
18. *Medically necessary telehealth services* subject to the same clinical and *utilization review* criteria, plan requirements, limitations and *cost sharing* as the same health care services when delivered to an insured in person.
19. For *medically necessary* genetic blood tests.
20. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
21. For *medically necessary* allergy treatment.
22. Allergy testing.
23. Infusion therapy.
24. Treatment of medically diagnosed cleft lip, cleft palate
    (1) "Cleft lip and palate" means a congenital cleft in the lip or palate, or both.
    (2) "*Medically necessary* care and treatment" shall include, but not be limited to:
        (a) oral and facial surgery, surgical management, and follow-up care made necessary because of a cleft lip and palate;
        (b) prosthetic treatment such as obturator, speech appliances, and feeding appliances;
        (c) medically necessary orthodontic treatment and management;

(d) medically necessary prosthodontic treatment and management;
(e) otolaryngology treatment and management;
(f) audiological assessment, treatment, and management performed by or under the supervision of a licensed doctor of medicine, including surgically implanted amplification devices; and
(g) *medically necessary* physical therapy assessment and treatment.

25. *Medically necessary covered service expenses* when performed by a podiatrist, oral surgeon and optometrist.

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

If *you* need mental health or *substance use disorder* treatment, *you* may choose any *provider* participating in *our provider network* and do not need a referral from *your PCP* in order to initiate treatment. You can search for in-network Behavioral Health providers by using our Find a Provider tool at ambetter.absolutetotalcare.com or by calling Member Services at 1-833-270-5443 (TTY 711). *Deductible amounts*, *copayment,* or *coinsurance* amounts and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

Covered services for mental health and *substance use disorder* are included on a non-discriminatory basis for all *members* for the diagnosis and treatment of mental, emotional, and/or *substance use disorders* as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association and the most recent edition of the International Classification of Diseases. Treatment is limited to services prescribed by *your physician* in accordance with a treatment plan.

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

Covered inpatient and outpatient mental health and/or *substance use disorder* services are as follows:

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

Outpatient
1. Individual and group mental health evaluation and treatment;
2. *Outpatient services* for the purpose of monitoring drug therapy;
3. Medication management services;
4. Outpatient detoxification programs;
5. Psychological and Neuropsychological testing and assessment;
6. Outpatient *rehabilitation* treatment;
7. *Applied Behavioral Analysis*;

8. Telehealth services;
9. Partial Hospitalization Program (PHP);
10. Intensive Outpatient Program (IOP);
11. Mental health day treatment;
12. Electroconvulsive Therapy (ECT);
13. Transcranial Magnetic Stimulation (TMS); and
14. Assertive Community Treatment (ACT)

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

In addition, Integrated Care Management is available for all of your healthcare needs, including behavioral health and substance use. Please call 1-833-270-5443 (TTY 711) to be referred to a care manager for an assessment.

Other Dental Services
Anesthesia and *hospital* charges for dental services, 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 services 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 services 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 and may require prior authorization:

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.

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

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

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

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

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance, unless listed on the formulary.
2. For immunization agents, blood, or blood plasma, except when used for preventive care or required by ACA and listed on the formulary.
3. For medication that is to be taken by the *member,* in whole or in part, at the place where it is dispensed.
4. For medication received while the *member* is a patient at an institution, that has a facility for dispensing pharmaceuticals.
5. For a refill dispensed more than 12 months from the date of a *physician's* order.
6. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
7. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary or when the over-the-counter drug is used for preventive care.
8. For drugs labeled "Caution - limited by federal law to investigational use" or for *investigational* or *experimental* drugs.
9. For more than a 30-day supply when dispensed in any one prescription or refill, or for some maintenance drugs up to a 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply network. Specialty drugs and other select drug categories are limited to 30-day supply when dispensed by retail or mail order. Please note that only the 90 days' supply is subject to the discounted cost sharing. Mail orders less than 90 days are subject to the standard cost-sharing amount.
10. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
11. Off-label use, except as required by law or as expressly approved by *us*.
12. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program.
13. Drugs or dosage amounts determined by us 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.
14. Foreign Prescription Medications, except those associated with an emergency medical condition while you are travelling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this section if obtained in the United States.
15. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
16. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventative treatment is related to member's vacation for out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
17. Medications used for cosmetic purposes.
18. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status. To facilitate appropriate benefit use and prevent opioid overutilization, member's participation in lock-in status will be determined by review of pharmacy claims.
19. For any prescription or over the counter version of vitamin(s) unless otherwise included 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.

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

Prescription Drug Exception Process

Standard exception request

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

Expedited exception request

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

External exception request review

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

If *we* grant an external exception review of a standard exception 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.

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 contact your PCP or provider. Your PCP or provider can utilize the usual prior authorization request process. See "Prior Authorization" for additional details.

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 Ambetter.pshpgeoriga.com (under "For Member", "Pharmacy Resources") or call Member Services at 1-833-270-5443 (TTY/TTD 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 ambetter.absolutetotalcare.com on the Find a Provider page. *You* can also call Member Services to help you find a pharmacy. At the pharmacy, you will need to provide the pharmacist with your prescription and *your* member ID card.

We also offer a three-month (90-day) supply of maintenance medications by mail or from in-network retail pharmacies for specific benefit plans. These drugs treat long-term conditions or illnesses, such as high blood pressure, asthma and diabetes. *You* can find a list of covered medications on ambetter.absolutetotalcare.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, our home delivery program might be right for *you*. If *you* select to enroll, you can get your prescriptions safely delivered right to *your* door. This service is fast, convenient and is offered at no extra charge to *you*. *You* will still be responsible for *your* regular *copays/coinsurance*. To enroll for home delivery or for any additional questions, call *our* mail order pharmacy at 1-888-239-7690. Alternatively, *you* can fill out the 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."

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

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. Examples of these services are screenings for breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, prostate specific antigen testing, and screenings for child and adult obesity.

a. Pap smears shall be covered on an annual basis unless recommended more frequently by *your provider*.

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. Examples of items covered without *cost sharing* include, but are not limited to:
    a. Screening for *tobacco or nicotine use*; and
    b. For those who *use tobacco or nicotine* products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
        i. Four (4) *tobacco* or *nicotine* cessation counseling sessions of at least (10) minutes each (including telephone counseling, group counseling, and individual counseling) without *prior authorization*; and
        ii. All (FDA) approved *tobacco or nicotine* 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 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 (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 an academic or NCI 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 NIH;
- The Centers for Disease Control and Prevention;

- The Agency for Health Care Research and Quality;
- The Centers for Medicare & Medicaid Services;
- A 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 HHS 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 (50) years of age; or less than (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 HHS, but not later than one year after the recommendation or guideline is issued.

Mammography
Covered service expenses for routine screenings for breast cancer shall include screenings at the following intervals: one (1) Baseline breast cancer screening mammography for a covered person between the ages of (35) and (40) years. If the covered person is less than (40) years of age and at risk, one (1) breast cancer screening mammography performed every year. If the covered person is at least (40) years of age but not yet (50) years of age, one (1) breast cancer screening mammography every other year. If the covered person is more than (50) years of age, one (1) breast cancer screening mammography every year, and any additional mammography views that are required for proper evaluation.

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 physician or other healthcare provider obtain *prior authorization*.

Other maternity services that 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 services. This provision also does not require an enrollee who is eligible for coverage under a health benefit plan to:

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

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

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

Newborns' and Mothers' Health Protection Act Statement of Rights
Health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in 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).

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

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 (50) years of age; and at least once

annually for a *covered person* who is less than (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 dependent members* 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. This *policy* will cover prostate cancer examinations, screenings, and lab work for diagnostic purposes in accordance with the more recent published guidelines of the American Cancer Society.

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, and 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 a hospice care program. Respite days that are applied toward the *deductible amount* are considered benefits provided and shall apply against any maximum benefit limit for these services. See *your Schedule of Benefits* for coverage limits.

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

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

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

Social Determinants of Health Supplemental Benefits
Social determinants of health supplemental benefits and services may be offered to *members* to remove barriers to accessing health services and improve overall health outcomes. These are benefits and services that we may make available in connection with this contract. The benefits and services provided may include transportation to health services, assistance with childcare, access to healthy meals, and other relevant services based on need. The benefits are available as long as coverage remains active, unless changed by us. Upon termination of coverage, the benefits are no longer available. All *members* are automatically eligible for the benefits upon obtaining coverage. The services are optional, and the benefits are made available at no additional cost to the members. 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 *members* through the "My Health Pays" *wellness program* and through local health plan websites. *Members* may receive notifications about available benefits and services through emails from local health plans and through the "My Health Pays" notification system. To inquire about these benefits and services or other benefits available, you may visit our website at https://ambetter.absolutetotalcare.com or by contacting Member Services at 1-833-270-5443 (TTY 711).

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

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

Transplant Expense Benefits
Covered Services and supplies 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*. Transplant services must be provided by an *in-network provider* and facility, and meet other medical criteria as set by medical management policy and the medical *providers* performing the transplant:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting.
3. Pre-transplant stabilization, meaning an *inpatient* stay to *medically stabilize* a *member* to prepare for a later transplant, whether or not the transplant occurs.
4. High dose chemotherapy.
5. Peripheral stem cell collection.
6. The transplant itself, not including the acquisition cost for the organ or bone marrow (except at a *Center of Excellence*).
7. Post-transplant follow-up.

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

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

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

1. For search and testing in order to locate a suitable donor.
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *medically necessary* transplant occurs.
3. For animal to human transplants.
4. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
5. To keep a donor alive for the transplant operation.
6. For a live donor's expenses where the live donor is receiving a transplanted organ to replace the donated organ.
7. Related to transplants not included under this provision as a *medically necessary* transplant.
8. For a *medically necessary* transplant under study in an ongoing phase I or II clinical trial as set forth in the *FDA* regulations, regardless of whether the trial is subject to *FDA* oversight.

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 1-833-270-5443. The 24/7 Nurse Advice Line is available (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.

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.

Vision Benefits– Adults 19 years of age or older
Coverage for vision services is provided for adults, age 19 and older, from *a network provider.*

1. Routine ophthalmological exam
   a. Refraction;
   b. Dilation;
   c. Contact lens fitting.
2. Frames
3. Prescription lenses
   a. Single;
   b. Bifocal;
   c. Trifocal;
   d. Lenticular; or
   e. Contact lenses (in lieu of glasses).

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

Services not covered:
1. Visual therapy;
2. Low vision services and hardware for adults; and
3. Non-network care without *prior authorization*.

Wellness and Other Program Benefits
Benefits may be available to *members* for participating in certain programs that we may make available in connection with this contract. Such programs may include *wellness programs*, disease or care management programs, and other programs as found under the Health Management Programs Offered provision. You may obtain information regarding the particular programs available at any given time by visiting our website at https://ambetter.absolutetotalcare.com or by contacting Customer Service by telephone at 1-833-270-5443 (TTY 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 *members* 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

member. 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 1-833-270-5443 (TTY/TDD 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.*
5. Any services where other coverage is primary to Ambetter must be first paid by the primary payor prior to consideration for coverage under Ambetter.

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

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

Covered 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 weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*, bariatric surgery and weight loss programs, except as specifically covered in the Major Medical Expense Benefits section of the *policy*.
4. For the reversal of sterilization and the reversal of vasectomies.
5. For abortion (unless the life of the mother would be endangered if the fetus were carried to term, or in cases of rape or incest).
6. 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.
7. For expenses for television, telephone, or expenses for other persons.
8. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
9. For telephone consultations, except those meeting the definition of telehealth services, or for failure to keep a scheduled appointment.
10. For stand-by availability of a *medical practitioner* when no treatment is rendered.
11. For *dental service* expenses*,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits.
12. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
13. Mental Health Services are excluded:
    a. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
    b. Pre-marital counseling;
    c. Court-ordered care or testing, or required as a condition of parole or probation. Benefits will be allowed for services that would otherwise be covered under this policy;
    d. Testing of aptitude, ability, intelligence or interest; and
    e. Evaluation for maintaining employment.

14. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
15. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
16. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *policy)*.
17. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*.
18. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.
19. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *policy*.
20. For hearing aids, except as expressly provided in this *policy*.
21. For *experimental* or *investigational treatment(s)* or *unproven services.* The fact that an *experimental* or *investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental* or *investigational treatment* or *unproven service* for the treatment of that particular condition.
22. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of ninety (90) consecutive days.
23. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's* workers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
24. For or related to surrogate parenting.
25. For or related to treatment of hyperhidrosis (excessive sweating).
26. For fetal reduction surgery.
27. Except as specifically identified as a *covered 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.
28. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); racing or speed testing any non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).
29. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
30. 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.
31. 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**;** 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*.

32. Diagnostic testing, laboratory procedures screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
33. For court ordered testing or care unless *medically necessary*.
34. For a *member's illness* or *injury which* is caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party.*
35. Private duty nursing.
36. 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.
37. For any medicinal and recreational use of cannabis or marijuana.
38. Surrogacy Arrangement. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a *member*, and any child born as a result of a *surrogacy arrangement*. This exclusion applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
    (a) Prenatal care;
    (b) Intrapartum care (or care provided during delivery and childbirth);
    (c) Postpartum care (or care for the *surrogate* following childbirth);
    (d) Mental Health Services related to the *surrogacy arrangement*;
    (e) Expenses relating to donor semen, including collection and preparation for implantation;
    (f) Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
    (g) Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
    (h) Preimplantation genetic diagnosis relating to a *surrogacy arrangement*;
    (i) Any complications of the child or *surrogate* resulting from the pregnancy; or
    (j) Any other health care services, supplies and medication relating to a *surrogacy arrangement*.

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

Termination

Termination of 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. For a dependent child reaching the limiting age of 26, coverage under this policy 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. The dependent child can be covered beyond the limiting age if they are both (a) incapable of self-sustaining employment by reason of intellectual disability or physical handicap and (b) chiefly dependent upon the policyholder or subscriber for support and maintenance, so long as proof of the incapacity and dependency is furnished to the insurer by the policyholder or subscriber within 60 days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two-year period following the child's attainment of the limiting age.
5. Upon reaching the limiting age, a dependent child may be issued a policy providing coverage which is most nearly similar to, but not greater than coverage under which they were formerly covered, if they apply for such coverage within 30 days following the attainment of the limiting age and pay all required premiums.
6. The date of *your* death, if this *policy* is an individual *policy*;
7. 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*; or
8. The date a *member's* eligibility for coverage under this *policy* ceases as determined by the Health Insurance Marketplace.
9. If a dependent spouse has had their coverage terminated due to divorce, they may apply for coverage within 60 days and, upon payment of the appropriate premiums, be provided with coverage which is most nearly similar to, but not greater than the coverage which they had received previously as a dependent.

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

If the renewal premium is not paid before the grace period ends the policy will lapse. Later acceptance of the premium by us or by an agent authorized to accept payment without requiring an application for reinstatement will reinstate the policy. If we or our agent requires an application, you will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the forty-fifth day after the date of the conditional receipt unless we have previously written you of our disapproval. The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement or sickness that starts more than ten days after such date.

In all other respects your rights and our rights will remain the same, subject to any provisions noted on or

attached to the reinstated policy. Any premiums we accept for reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days before the reinstatement date. This applies only to policies for which you are not receiving a premium subsidy.

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.

Right of Reimbursement

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

If this policy provides benefits to a *member* for expenses incurred due to third party injuries, then we retain the right to repayment of the full cost of all benefits provided by this plan on behalf of the *member* that are associated with the third party injuries. Our rights of recovery apply to any recoveries made by or on behalf of the *member* from any sources, including but not limited to:

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

By accepting benefits under this plan, the *member* specifically acknowledges our right of recovery. When this plan provides health care benefits for expenses incurred due to third party injuries, we shall be included in the *member's* rights of recovery against any party to the extent of the full cost of all benefits provided by this plan. We may proceed against any party with or without the *member's* consent.

By accepting benefits under this plan, the *member* also specifically acknowledges our right of reimbursement. This right of reimbursement attaches when this plan has provided health care benefits for expenses incurred due to third party injuries and the *member* or the *member's* representative has recovered any amounts from any source. Our right of reimbursement is cumulative with and not exclusive our right of recovery and we may choose to exercise either or both rights of recovery.

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

1. To fully cooperate with *us* in order to obtain information about the *loss* and its cause.
2. To immediately inform *us* in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.
3. To include the amount of benefits paid by *us* on behalf of a *member* in any claim made against any *third party*.
4. To give us a first-priority lien on any recovery, settlement or judgment or other sources of compensation which may be had from any party to the extent of the full cost of all benefits associated with third party injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
5. To pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due us as reimbursement for the full cost of all benefits associated with Third Party injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement).
6. That *we*:
    a. Will have a lien on all money received by a *member* in connection with the *loss* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.
    d. Are entitled to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert the right of reimbursement independently of the *member*.

7. To take no action that prejudices *our* reimbursement rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan.
8. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement rights.
9. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
10. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
11. That *we* may reduce other benefits under the *policy* by the amounts a *member* has agreed to reimburse *us*.

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

We will not pay attorney fees or costs associated with the *member's* claim or lawsuit. In the event *you* or *your* representative fail to cooperate with us, *you* shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by us.

If a dispute arises as to the amount a *member* must reimburse *us*, the *member* (or the guardian, legal representatives, estate, or heirs of the *member*) agree to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by *us* until the dispute is resolved.

Claims

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

Proof of Loss
We must receive written *proof of loss* within 90 days of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than one year late will not be accepted, unless *you* or *your* covered *dependent member* had no legal capacity to submit such proof during that year. When we receive notice of claim, we will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limits stated in this Proof of Loss section.

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 p*rovider. *You* also need to submit an explanation of why *you* paid for the *covered services* along with the *member* reimbursement claim form posted at ambetter.absolutetotalcare.com under "Member Resources". Send all the documentation to *us* at the following address:

Ambetter from Absolute Total Care
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 to you, or to the provider to whom you have assigned payment of benefits, within 40 days for clean claims filed on paper and within 20 days for clean claims filed electronically. "Clean claims" means a claim submitted by *you* or a provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If *we* have not received the information *we* need to process a claim, *we* will ask for the additional information necessary to complete the claim. *You* will receive a copy of that request for additional information. In those cases, *we* cannot complete the processing of the claim until the additional information requested has been received. *We* will make *our* request for additional information within 20 days of *our* initial receipt of the claim if it was submitted electronically and within 40 days if it was submitted on paper. *We* will complete *our* processing of the claim within 30 days after *our* receipt of all requested information.

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

Change of Beneficiary
The insured can change the beneficiary at any time by giving the company written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

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

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

Foreign Claims Incurred For Emergency Care
Claims incurred outside of the United States for *emergency* care and treatment of a *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 policy 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 policy 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*, and other information as may be necessary for the child to obtain benefits through that coverage;
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*.

In addition, we will:

(1) permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(2) if the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of:

(a) the child's other parent;

(b) the state agency administering the Medicaid program; or

(c) the state agency administering 42 U.S.C. Sections 651 to 669, the child support enforcement program; and

(3) continue coverage of the child unless the insurer is provided satisfactory written evidence that the:

(a) court order is no longer in effect;

(b) child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment; or

(c) employer has eliminated family health coverage for all of its employees.

Physical Examination
We shall have the right and opportunity to examine a *member* while a claim is pending or while a dispute over the claim is pending. These examinations are made at *our* expense and as often as *we* may reasonably require. In cases of death of the member, *we* may have an autopsy performed during the period of contestability at *our* own expense unless prohibited by law. The autopsy must be performed in South Carolina.

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 six years after the date *proof of loss* is required.

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

No Third Party Beneficiaries
This *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

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

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

Call Member Services
Please contact our Member Services team at Customer Service Phone Number (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.

When *we* make an Adverse Benefit Determination, we will send the claimant and/or their authorized representative a notification that includes information to file an appeal and how to authorize a representative. Claimants have 180 calendar days to file an appeal from the date we issue the Adverse Benefit Determination.

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

Appeal
Claimants have the right to submit written comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process.

Appeal will be promptly investigated and presented to the internal *grievance* panel. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of an appeal. A request for an appeal must be submitted within 180 days following receipt of an *adverse benefit determination*.

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

Ambetter from Absolute Total Care
Grievances and Appeals Department
12515-8 Research Blvd, Ste. 400
Austin, TX 78759
Fax 1-833-886-7956

Claimants can also file an appeal via phone by contacting us at 1-833-270-5443 (TTY 711). Verbal requests must be followed up in writing.
Call *us* at 1-833-270-5443 (TTY 711) if *you* have any questions regarding the process or how to file an appeal. *We* will get an interpreter or TTY/TDD services for you if you need them.

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

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

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

Your or your authorized representative has the right to appear in person before the *grievance* panel to present written or oral information. The grievant may submit written questions to the person or persons responsible for making the determination that resulted in the *grievance*.

1. Written notification must be sent to the claimant indicating the time and place of the *grievance* panel meeting at least seven calendar days before the meeting; and
2. Reasonable accommodations must be provided to allow the claimant, or the claimant's authorized representative, to participate in the *grievance* panel.

A reviewer of the same or similar specialty as the provider who requested the service will review the request and make a determination. This reviewer will not be the physician involved in the original decision and who is not the subordinate of that physician. 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. The notice will include an explanation of *our* decision, a reference to the criteria on which the decision was based, a list of the title and qualifications of each person participating in the review, and a description of *your* further appeal rights. *Your* further appeal rights include the right to an External Review.

Expedited Appeal
You can file an expedited appeal when a requested service involves a situation that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. This type of appeal must be documented with clinical information. *You* may request an expedited appeal at any time. *You* may start the appeal by phone or in writing. *You* may call 1-833-270-5443 (TTY 711) to initiate an expedited appeal request. *We* will make a decision about the request within 72 hours. *We* will notify you and *your* Provider of the result. Due to the 72-hour resolution timeframe, the standard requirements for notification, *grievance* panel/right to appear, and acknowledgement do not apply to *expedited grievances*.

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

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

Appeal Panel

The *appeal* panel will not include the person who made the initial determination nor any person who is the subordinate of the original reviewer. The panel may, however, consult with the initial decision-maker. If the panel consists of at least three persons, the panel may then include no more than one subordinate of the person who made the initial determination.

The *appeal* panel will include:

1. At least one individual authorized to take corrective action on the *appeal*; and
2. At least one insured other than the *appellant*, if an insured is available to serve on the *appeal* panel. The insured member of the panel shall not be an employee of the plan, to the extent possible.

When the *adverse benefit determination* is based in whole or in part on a medical judgment, the *appeal* panel will consult with a licensed health care *provider* with expertise in the field relating to the *appeal* and who was not consulted in connection with the original *adverse benefit determination*.

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

External Review

An external review decision is binding on *us*. An external review decision is binding on the claimant except to the extent the claimant has other remedies available under applicable federal or state law. *You* must make your request for an external review within four months of receiving notice that an adverse decision has been made under *our* internal appeal process. A decision will be made within 72 hours of the receipt of an expedited request, and within 45 days of the receipt of a standard request. *We* will pay for the costs of the external review performed by the independent reviewer.

We will request an external review and assignment of an *IRO* from the South Carolina Department of Insurance. *We* submit this request to:

Director Ray Farmer
South Carolina Department of Insurance
P.O. Box 100105
Columbia, South Carolina 29202-3105
Phone: (803) 737-6150

After exhausting the internal review process, the claimant has four months to make a written request to the Grievance Administrator for external review after the date of receipt of *our* internal response.

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

External review is available for *appeals* that involve:

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

External Review Process

1. *You* have 60 calendar days to request a standard external review and 15 days to request an expedited external review.
2. *We* have five business days (immediately for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether:
    a. The individual was a *covered person* at the time the item or service was requested;
    b. The service is a *covered service* under the claimant's policy but for the policy's *adverse benefit determination* with regard to medical necessity experimental/investigational, medical judgment, or *rescission*;
    c. The claimant has exhausted the internal process; and
    d. The claimant has provided all of the information required to process an external review.
3. Within one business day (immediately for expedited) after completion of the preliminary review, *we* will notify the claimant in writing as to whether the request is complete but not eligible for external review and the reasons for its ineligibility or , if the request is not complete, the additional information needed to make the request complete;
4. *We* must allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of notification;
5. *We* will notify the Department of the claimant's request for external review;
6. The Department will assign an IRO on a rotating basis;
7. *We* will verify that no conflict of interest exists with the assigned IRO (if a conflict does exist, we will contact the Department for an additional assignment);
8. Within five business days of the Department's assignment of an IRO, *we* will notify the claimant in writing of the assignment to an IRO and the claimant's right to submit additional information to be

considered by the IRO. If the claimant provides the IRO information within the five-day timeframe, the information will be considered in the review. This information must be shared with *us* within one business day of receipt by the IRO.

9. Within five (5) business days after the date of assignment of the IRO, *we* must provide the documents and any information considered in making the *adverse benefit determination* to the IRO. **Note:** For expedited, after assignment of the IRO, *we* must provide the documents and any information considered in making the *adverse benefit determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method;
10. If *we* fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the *adverse benefit determination*;
11. Within 10 business days, the assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the claimant may submit in writing additional information to the IRO to consider;
12. Upon receipt of any information submitted by the claimant, the IRO must forward the information to *us* within one (1) business day;
13. Upon receipt of the information, *we* may reconsider *our* determination. If *we* reverse *our adverse benefit determination*, *we* must provide written notice of the decision to the claimant and the IRO within one business day after making such decision. The external review would be considered terminated;
14. Within 45 days (72 hours for expedited) after the date of receipt of the request for an external review by the health plan, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to the claimant and to *us*. If the notice for an expedited review is not in writing, the IRO must provide written confirmation within 48 hours after the date of providing the notice; and
15. Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, *we* will approve the benefit that was the subject of the *adverse benefit determination*.

Written Appeal Response

Appeal response letters shall describe, in detail, the *appeal* procedure and the notification shall include the specific reason for the denial, determination, or initiation of disenrollment.

The panel's written decision to the grievant must include:

1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *appeal*;
3. The signature of one voting member of the panel; and
4. A written description of position titles of panel members involved in making the decision.
5. If upheld or partially upheld, it is also necessary to include:
    a. A clear explanation of the decision;
    b. Reference to the specific policy provision on which the determination is based;
    c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant 's claim for benefits;
    d. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
    e. If the *adverse benefit determination* is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the policy to the claimant 's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

f. Identification of medical experts whose advice was obtained on behalf of the policy, without regard to whether the advice was relied upon in making the *adverse benefit determination*;
g. The date of service;
h. The health care *provider's* name;
i. The claim amount;
j. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
k. The health policy's denial code with corresponding meaning;
l. A description of any standard used, if any, in denying the claim;
m. A description of the external review procedures, if applicable;
n. The right to bring a civil action under state or federal law;
o. A copy of the form that authorizes the policy to disclose protected health information, if applicable;
p. That assistance is available by contacting the specific state's consumer assistance department, if applicable; and
q. A culturally linguistic statement based upon the claimant's county or state of *residence* that provides for oral translation of the *adverse benefit determination*, if applicable.

Complaints

Basic elements of a *complaint* include:

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

Grievance Procedures

You or your authorized representative may file a grievance by calling our Member Services Team at 1-833-270-5443 (TTY 711) or in writing by mailing or faxing your grievance to:

Ambetter from Absolute Total Care
Grievances and Appeals Department
12515-8 Research Blvd, Ste. 400
Austin, TX 78759
Fax 1-833-886-7956

If filing a written grievance, please include:

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

Processing Your Grievance
We will acknowledge your grievance by sending you a letter within five calendar days of receipt of your grievance.

Grievances will be promptly investigated, and will be resolved within 30 calendar days (72 hours for clinical urgent grievances) of receipt. We will notify you in writing within 30 calendar days of the outcome. The time period may be extended for an additional 14 calendar days, making the maximum time for the entire grievance process 44 calendar days if we provide you or your authorized representative, if applicable, written notification of the following within the first 30 calendar days:

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

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

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

Appeals and Grievances filing and key communication timelines

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard Grievance	N/A	5 Calendar Days	30 Calendar Days	14 Calendar Days
Standard Pre-Service Appeal	180 Calendar Days	5 Calendar Days	30 Calendar Days	14 Calendar Days
Expedited Pre-Service Appeal	180 Calendar Days	N/A	72 Hours	14 Calendar Days
Standard Post-Service Appeal	180 Calendar Days	5 Calendar Days	60 Calendar Days	14 Calendar Days
External Review	60 Calendar Days	5 Calendar Days	45 Calendar Days	N/A
Expedited External Review	15 Calendar Days	Immediately	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 *you or we* 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.

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*.

Time Limit on Certain Defenses
After two years from the issue date of the fraud, misrepresentation or knowingly provides false information in the application may be used to void the policy or deny any claim for loss incurred or disability that starts after the two-year period. You have the right to continue your policy with us by a payment of premium (A) until at least age fifty or (B) in the case of a policy issued after age forty-four, for at least five years from its date of issue. After this policy has been in force for two years, we will not contest the statements contained in the application. Any loss or disability claims that start after two years from the date of insurance will not be reduced or rejected, because there was an illness or physical condition before the effective date of the insurance, and there was no illness before the insurance date.

Conformity with State Laws
Any part of this *policy* in conflict with the laws of South Carolina on this *policy's effective date* or on any premium due date is changed to conform to the minimum requirements of South 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:// ambetter.absolutetotalcare.com /privacy-practices.html or call Member Services at 1-833-270-5443 (TTY 711). *We* protect all of your PHI. *We* follow HIPAA to keep your healthcare information private.

Language
If *you* don't speak or understand the language in *your* area, you have the right to an interpreter. For language assistance, please visit: ambetter.absolutetotalcare.com.

Statement of Non-Discrimination

Ambetter from Absolute Total Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Except as permitted by law, Ambetter from Absolute Total Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Absolute Total Care:

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

If you need these services, contact Ambetter from Absolute Total Care at 1-833-270-5443 (TTY/TDD 711).

If you believe that Ambetter from Absolute Total Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ambetter from Absolute Total Care, ATTN: Grievances and Appeals Department, 12515-8 Research Blvd, Suite 400, Austin, TX 78759, Phone 1-833-270-5443 (TTY/TDD 711), Fax 1-833-886-7956. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from Absolute Total Care 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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Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Absolute Total Care, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-270-5443 (Relay 711).
Chinese:	如果您，或是您正在協助的對象，有關於Ambetter from Absolute Total Care,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1-833-270-5443 (Relay 711).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Absolute Total Care, 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 1-833-270-5443 (Relay 711).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Ambetter from Absolute Total Care,에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-833-270-5443 (Relay 711).]. 로 전화하십시오.
French:	Si vous-même ou une personne que vous aidez avez des questions à propos Ambetter from Absolute Total Care, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-833-270-5443 (Relay 711).
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Absolute Total Care, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa1-833-270-5443 (Relay 711).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Absolute Total Care, вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-833-270-5443 (Relay 711).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Absolute Total Care, 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 1-833-270-5443 (Relay 711).an.
Gujarati:	જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter from Absolute Total Care, વિશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-833-270-5443 (Relay 711) ઉપર કૉલ કરો.
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Absolute Total Care، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-833-270-5443 (Relay 711).
Portuguese:	Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from Absolute Total Care, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-833-270-5443 (Relay 711).
Japanese:	Ambetter from Absolute Total Care, 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、1-833-270-5443 (Relay 711) までお電話ください。
Ukrainian:	В разі виникнення у вас або особи, якій ви допомагаєте, будь-яких запитань щодо програми страхування Ambetter from Absolute Total Care ви маєте право отримати безкоштовну допомогу та інформацію на своїй рідній мові. Щоб поговорити з перекладачем, зателефонуйте за номером 1-833-270-5443 (Relay 711).
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from Absolute Total Care, 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 1-833-270-5443 (Relay 711) पर कॉल करें।
Mon-Khmer, Cambodian:	ប្រសិនបើអ្នកឬនរណាម្នាក់ដែលអ្នកកំពុងតែជួយមានបញ្ហាអំពី Ambetter from Absolute Total Care អ្នកមានសិទ្ធិទទួលបានជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមនិយាយទៅកាន់អ្នកបកប្រែតាមរយៈ 1-833-270-5443 (Relay 711)

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