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2021 Evidence of Coverage

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91450AZ008

MAJOR MEDICAL EXPENSE INSURANCE POLICY

AMBETTER FROM ARIZONA COMPLETE HEALTH

Home Office: 1870 W. Rio Salado Parkway, Suite 2A, Tempe, AZ 85281

ISSUED BY

AMBETTER FROM ARIZONA COMPLETE HEALTH

Tempe, Arizona

Welcome to Ambetter from Arizona Complete Health. This booklet is *your policy*. It explains what *your* benefits are, how *you* can access these benefits, and the limitations and exclusions that apply to *covered services*. In this *policy*, the terms "*You*" or "*Your*" will refer to the covered person as the *member* enrolled in this *policy***,** and "*We*," "*Our*" or "*Us*" will refer to Ambetter from Arizona Complete Health ("Ambetter"). For *your* convenience, *we* have included a Definitions Section, which will explain the meaning of special words and phrases used throughout this *policy*. Be sure to check these definitions as they may differ from other Health Plans.

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 timely payment of premiums, *we* will provide healthcare benefits to *you*, the *member*, for *covered services* as outlined in this *policy*. Benefits are subject to *policy* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

Annually, *we* must file this product, the *cost share* and the rates associated with it for approval. Guaranteed renewable means that *your* plan will be renewed into the subsequent year's approved product on the anniversary date unless terminated earlier in accordance with *policy* terms. *You* may keep this *policy* (or new *policy you* are mapped to for the following year) in force by timely payment of the required premiums. In most cases you will be moved to a new contract 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; or (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 covered person in filing a *claim* for *policy* benefits.

In addition to the above, this guarantee for continuity of coverage shall not prevent *us* from cancelling or non-renewing this *policy* in the following events: (1) non-payment of premium; (2) a *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the *policy*; or (3) a change in federal or state law, no longer permits the continued offering of such coverage, such as CMS guidance related to individuals who are Medicare eligible.

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

At least thirty-one (31) days' notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in our records. *We* will make no change in

your premium solely because of *claims* made under this *policy* or a change in a covered person's health. While this *policy* is in force, *we* will not restrict coverage already in force. Changes to this *policy* will be approved by the Arizona Department of Insurance.

This *policy* contains *prior authorization* requirements. *You* may be required to obtain a *referral* from a *Primary Care Provider* (PCP) 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.

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

TEN DAY RIGHT TO RETURN

THIS *POLICY* SHOULD BE READ CAREFULLY. IF *YOU* HAVE QUESTIONS, CALL MEMBER SERVICES AT 1-888-926-5057 (TTY: 711). IF *YOU* ARE NOT SATISFIED WITH THIS *POLICY*, *YOU* MAY RETURN IT, IN PERSON OR BY MAIL, ALONG WITH *YOUR* IDENTIFICATION CARD TO AMBETTER FROM ARIZONA COMPLETE HEALTH, 1870 W. RIO SALADO PARKWAY, SUITE 2A, TEMPE, ARIZONA 85281, WITHIN 10 DAYS FROM THE DATE IT WAS RECEIVED SO LONG AS COVERED SERVICES UNDER THIS *POLICY* HAVE NOT BEEN UTILIZED DURING THE 10 DAY PERIOD. IMMEDIATELY UPON SUCH DELIVERY OR MAILING, THIS *POLICY* SHALL BE DEEMED VOID AS OF ITS ORIGINAL EFFECTIVE DATE. ANY PREMIUM PAID WILL BE REFUNDED WITHIN 10 DAYS OF ARIZONA COMPLETE HEALTH'S RECEIPT OF THE RETURNED *POLICY*.

Arizona Complete Health

By:

Martha Smith
Plan President & CEO, Arizona Complete Health

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INTRODUCTION

PLEASE READ THIS IMPORTANT NOTICE ABOUT YOUR PLAN

AMBETTER FROM ARIZONA COMPLETE HEALTH SERVICE AREA AND OBTAINING SERVICES FROM THE NETWORK PHYSICIANS HOSPITAL PROVIDERS

You are enrolled in an Ambetter from Arizona Complete Health. Benefits under this *policy* are only available when *you* use an Ambetter from Arizona Complete Health *Network Provider* (except as stated below) and live in the Ambetter from Arizona Complete Health Service Area.

Obtaining Covered Services and Supplies under this *Policy:*

Please refer to this *policy* whenever *you* require *medical services*.

It describes:

- How to access medical care.
- The healthcare services *we* cover.
- The portion *your* healthcare 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 or 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 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.

If *you* have any questions about the Ambetter from Arizona Complete Health, choosing *your Primary Care Provider* (PCP), how to access *specialist* care, or *your* benefits, please contact Member Services at 1-888-926-5057 (TTY: 711).

How to Contact Us

Ambetter from Arizona Complete Health
1870 W. Rio Salado Parkway, Suite 2A
Tempe, AZ 85281

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

Member Services	1-888-926-5057
TDD/TTY	711
Fax	1-866-687-0518
Emergency	911
24/7 Nurse Advice Line	1-888-926-5057 (TTY: 711)

Language Assistance

Ambetter from Arizona Complete Health has a free service to help *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 interpreters are provided at no cost to *you*. *We* have medical interpreters to assist with languages other than English via phone. An interpreter will not go to a *provider's* office with *you*.

Members who are blind or visually impaired and need help with reading documents can call Member Services for an oral interpretation or to have documents translated into braille or large font.

To arrange for interpreter services, please call Member Services at 1-888-926-5057 or for the hearing impaired (TTY: 711).

HEALTH SAVINGS ACCOUNT (HSA)

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

Your high-deductible *health plan* may be used in conjunction with an HSA. However, individual *members* must satisfy federal HSA eligibility criteria in order to open and contribute to an HSA.

This *policy* is administered by Ambetter from Arizona Complete Health and is not an HSA trustee, HSA custodian or a designated administrator for HSA's. Arizona Complete Health, its designee's, and its affiliates do not provide tax, investment or legal advice to *members*.

MEMBERS ARE SOLELY RESPONSIBLE FOR ADHERING TO ALL FEDERAL REGULATIONS AND GUIDELINES CONCERNING HSA ELIGIBLE EXPENSES, CONTRIBUTIONS AND QUALIFIED WITHDRAWALS. IN ADDITION, EACH MEMBER WITH AN HSA IS RESPONSIBLE FOR NOTIFYING THEIR HSA CUSTODIAN OR TRUSTEE IF ENROLLMENT UNDER THIS PLAN HAS BEEN CANCELED OR TERMINATED.

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

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

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 *your providers*.
3. Providing information to help *you* become an informed healthcare consumer.
4. Providing access to *covered services* and *our network providers*.
5. Providing coverage regardless of age, ethnicity, race, religion, gender identity, sexual orientation, national origin, physical or mental disability, and/or expected health or genetic status.

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

You have the right to:

1. Participate with *your providers* in decisions about *your* healthcare. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or *your* legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our network* of *physicians* and Medical Practitioners, *your* rights and responsibilities and *our* policies.
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. Voice Complaints or *grievances* about *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
9. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician(s)* of the medical consequences.
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 *authori-*

zations, benefit denials, *member* rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 30 days before the *effective date* of the modifications. Such notices shall include 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 another *health plan* or switch health plans, within the guidelines of law, without any threats or harassment.
14. Adequate access to qualified *physicians* and Medical Practitioners and treatment or services regardless of age, race, sex, sexual orientation, family structure, geographic location, health condition, 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. Refu*s*e 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 disc*uss* all concerns about treatment with *your Primary Care Provider*. *Your Primary Care Provider* can disc*uss* 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, available by phone, if *you* do not speak or understand English.
21. A second opinion by a *network provider* of *your* choice, if *you* want more information about *your* treatment or would like to explore additional treatment options.
22. Make an Advance Directive 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 *your*self. Examples of Advance Directives include:
    a. Living Will
    b. Healthcare Power of Attorney
    c. "Do Not Res*us*citate" Orders

    Members also have the right to refuse to make Advance Directives. *You* should not be discriminated against for not having an Advance Directive.

You have the responsibility to:

1. Read this entire *contract*.
2. Treat all healthcare professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of *your 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 *us*e of *covered services*.
5. Show *your* I.D. 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 Primary Care Provider*. *You* may change *your Primary Care Provider* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* healthcare professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* healthcare professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* healthcare professionals and *physicians*.
11. Tell *your* healthcare professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with *your 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. *Us*e any Emergency Room only when *you* think *you* have a medical *emergency*. For all other care, *you* should call *your Primary Care Provider* or access an *Urgent Care facility*.
14. Provide all information about any other medical coverage *you* have upon enrollment in this plan. If, at any time, *you* get other medical coverage besides this coverage, *you* m*us*t tell the entity with which *you* enrolled.
15. Pay *your* monthly premium on time and pay all *deductible amounts*, *copayment amounts*, or *cost sharing percentages*. *Copayment Amounts* must be paid at the time of service.
16. Receive all of *your* healthcare services and supplies from *network providers*, except as specifically stated in this *contract*.
17. Inform the entity in which *you* enrolled for this *policy* if *you* have any changes to *your* name, address, or *family members* covered under this *policy* within 60 days from the date of the event.

IMPORTANT INFORMATION

Your Provider Directory
A listing of *network providers* is available online at https://ambetter.azcompletehealth.com/. *We* have plan *physicians*, *hospitals*, and other Medical Practitioners who have agreed to provide *you* healthcare services. *You* can find *our network providers* by visiting *our* website and *us*ing the "Find a Provider" function. There *you* will have the ability to narrow *your* search by *provider* specialty, zip code, gender, whether or not they are currently accepting new patients, and languages spoken. *Your* search will produce a list of *providers* based on *your* search criteria and will give *you* other information such as address, phone number, office hours, and qualifications.

At any time, *you* can request a printed copy of the provider directory at no charge by calling Member Services at 1-888-926-5057 (TTY: 711). In order to obtain benefits, *you* m*us*t designate a *network primary care provider* for each *member*. *We* can help *you* pick a *primary care provider*. We can make *your* choice of *primary care provider* effective on the next b*us*iness day, if the selected *physician's* caseload permits. *We* will notify *you* if *your primary care provider* leaves *our network. You* will be provided continued access, and *your coverage* will continue under the terms of this *contract* for at least sixty (60) days from that notice.

Call the *provider's* office if *you* want to make an appointment. If *you* need help, call Member Services at 1-888-926-5057 (TTY: 711).

Your Member ID Card
When *you* enroll, *we* will mail 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 a Coordinated Care 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 number, the phone numbers for Member Services, pharmacy and 24/7 Nurse Advice Line, 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 1-888-926-5057 (TTY: 711). *We* will send *you* another card.

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

1. Finding a *network provider*.
2. *Our* programs and services, including programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the stat*us* of *your claims*, make payments and obtain a copy of *your* Member ID Card.
4. *Member* Rights and Responsibilities.
5. Notice of Privacy.
6. Current events and news with *your* Ambetter plan.
7. *Our Formulary*.
8. Selecting a *Primary Care Provider*.
9. *Deductible* and *copayment amounts*.
10. Making *your* premium payment.

Quality Improvement

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

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

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

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

DEFINITIONS

This section tells *you* meanings of some of the more important words *you* will see used in this *policy*. Please read it carefully. It will help *you* understand this *policy*.

Accident or ***Accidental*** means an unexpected, undesirable event that was unforeseen.

Acute means the sudden onset of an *illness* or *injury*, or a sudden change in a person's health stat*us*, requiring prompt medical attention, but which is of limited duration as determined by *us*.

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

Advanced Premium Tax Credit means payment of the tax credits specified in section 36B of the Internal Revenue Code (as added by section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual enrolled in a qualified health plan through a *Marketplace* in accordance with sections 1402 and 1412 of the Affordable Care Act. If *we* do not receive *Advanced Premium Tax Credits* with respect to *your* coverage for whatever reason, *your* coverage may be terminated.

Adverse Benefit Determination means a decision by *us* which results in:

1. A denial of a request for service.
2. A denial, reduction or failure to provide or make payment in whole or in part for a covered benefit.
3. A determination that an admission, continued stay, or other health care service does not meet *our* requirements for *medical necessity*, appropriateness, health care setting, or level of care or effectiveness.
4. A determination that a service is *experimental*, *investigational*, *cosmetic* treatment, not *medically necessary* or inappropriate.
5. *Our* decision to deny *coverage* based upon an eligibility determination.
6. A rescission of *coverage* determination as described in the General Provisions section of this *policy*.
7. A prospective review or retrospective review determination that denies, reduces or fails to provide or make payment, in whole or in part, for a covered benefit.

Refer to the Health Care Appeals & Grievance section of this *policy* 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.

Ambulance means a vehicle superficially designed, equipped and licensed for transporting the sick and/or injured.

Ambulatory Surgical Facility means a *facility* that meets the states' statutorily and/or professionally recognized standards and provides the following:

1. It mainly provides a setting for *outpatient* surgeries; and,
2. It does not provide more than 2 days of *inpatient* service; and,
3. It has all of the medical equipment needed to support the surgery performed, x-ray and laboratory diagnostic *facilities*, and *emergency* equipment and supplies for *use* in life threatening events; and,
4. It has a medical staff that is supervised full-time by a *physician* and includes a registered nurse at all times when patients are in the *facility*; and,
5. It maintains a medical record for each patient; and,
6. It has a written agreement with a local *hospital* for the immediate transfer of patients who require greater care than can be furnished at the *facility*; and,
7. It complies with all state and/or federal licensing and other requirements; and,
8. It is not the office or clinic of one or more *physicians*.

Ancillary Services are services that can be classified into three categories: diagnostic, therapeutic, and custodial. Ancillary services can include laboratory tests, radiology, anesthesiology, diagnostic imaging, and other services.

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

Authorization or ***Authorized*** (also "*Prior Authorization*" or "*Approval*") means a 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 a health care appeal or external review process of an adverse benefit determination who is any of the following:

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

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

Balance Billing means a *non-network provider* billing *you* for the difference between the *provider's* charge for a service and the *eligible service expense* for *covered services*. *Network providers* may not *balance bill you* for *covered expenses* beyond *your* applicable *cost sharing* amounts. If *you* are ever balance billed contact Member Services immediately at the number listed on the back of *your* ID card.

Behavioral Therapy means interactive therapies derived from evidence based research, including *applied behavior analysis*, which includes discrete trial training, pivotal response training, intensive intervention programs and early intensive behavioral intervention.

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

Birth Center means a *facility* that is primarily a place for the delivery of a child at the end of a normal pregnancy, and meets all of the following tests:

1. It complies with all licensing and other legal requirements;
2. It is equipped to perform all of the needed routine diagnostic and laboratory tests;
3. It has a medical staff that is supervised full-time by a *physician*, or, at their direction, by a *nurse midwife*, and that includes a registered nurse at all times when patients are in the *facility*;
4. It has all the medical equipment necessary to properly treat potential *emergencies* of the child-bearer and child;
5. It has a written agreement with a local *hospital* for the immediate transfer of a patient in the event of a complication;
6. It maintains a medical record for each patient; and
7. It expects to discharge or transfer to a *hospital*, each patient within 48 hours of the delivery.

Brand Name Drug or ***Brand Name*** means a *Prescription Drug* that has been given a *brand name* or trade name by its manufacturer and is advertised and sold under that name or is classified as such by national pharmaceutical database companies.

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

Care Management is a program in which a licensed professional, known as a care manager, assists a *member* through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and healthcare benefits available to a *member*. *Care management* is instituted at the sole option of *us* when mutually agreed to by the *member* and the *member's 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.*

Chronic Health Conditions mean those conditions in which the patient's condition is either stabilized at a functional level or progressively deteriorating to the point where the *health professional* has determined that active *short-term* health treatment will not result in any reasonable expectation for improvement.

Claims means invoices or other standard billing documents containing details of health care services provided to a Member that a *provider* of health care services submits for payment, or that a Member submits to *us* for reimbursement.

Claims Forms means any document supplied by an insurer to an insured, claimant or other person that the insured, claimant or other person is required to complete and submit in support of a *claim* for benefits.

Coinsurance means the percent of a Covered Charge that the Member m*us*t pay for *covered services and supplies*. *Coinsurance* amounts are shown in the *Schedule of Benefits*. For example, *coinsurance* may be shown as 20%. This means that 20% of *covered expenses* are paid by the Member and 80% are paid by *us*. Not all *covered services* have *coinsurance*.

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

Complications of Pregnancy means:

1. When pregnancy is not terminated: conditions whose diagnoses are distinct from pregnancy but are adversely affected by or caused by pregnancy, such as *acute* nephritis, nephrosis, cardiac decompensation, missed abortion; disease of the following body systems - vascular, hemopoietic, nervo*us*, endocrine, toxemia (pre-eclampsia);
2. When pregnancy is terminated: non-elective caesarian section, ectopic pregnancy that is terminated, or spontaneo*us* termination of pregnancy that occurs during a period of gestation when a viable birth is not possible. Viable birth means that the fet*us* has reached a stage that will permit it to live outside the uter*us* and is capable of living outside the uter*us*;
3. *Complications of Pregnancy* do not include multiple births, preterm labor, false labor, occasional spotting, *physician* prescribed rest during the period of pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy that do not constitute a nosologically distinct complication of pregnancy.

Concurrent Review means the examination of ongoing medical care by *us* to determine the *medical necessity*, appropriateness, and level of care.

Congenital Anomaly or ***Congenital Defect*** means a defective development or formation of a part of the body which is determined to have been present at the time of birth.

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

Contracted Rate means the rate that *network providers* are allowed to charge *you*, based on a *contract* between *us* and such *provider*. *Covered expenses* for services provided by a *network provider* will be based on the *contracted rate*.

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 or ***Cosmetic Surgery*** means surgical procedures, including plastic surgery or other treatment that *we* determine to be directed toward preserving, altering or enhancing appearance, whether or not for emotional or psychological reasons.

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

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

Cost Sharing Reductions means reductions in *cost sharing* for an eligible individual enrolled in a silver level plan in the *Health Insurance Marketplace* or for an individual who is an American Indian and/or Alaskan Native enrolled in a QHP in the *Health Insurance Marketplace*.

Coverage means health care services and treatments which are covered under this *Policy*.

Covered Expenses means expenses for *medically necessary covered services and supplies*. Expenses in excess of eligible service expenses, will not be considered *covered expenses* under the *Policy*.

Covered Service(s) **and** ***Supplies*** means *medically necessary* services, supplies or benefits that are payable or eligible for reimbursement under this *Policy*, including any amendments hereto subject to any benefit limitations, or maximums under this *Policy* and/or performed by *providers* within the scope of their practice. The fact that a *network provider* may prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it a Covered Service.

Custodial Care means provision of room and board, nursing care (excluding skilled nursing care), and personal care designated to assist an individual who in the opinion of *our* Medical Director has reached the maximum level of recovery. *Custodial care* also includes rest cures, respite care, and home care that is or can be performed by *family members* or non-medical personnel.

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

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

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

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

The *deductible amount* does not include any *copayment amounts.* Not all services are subject to the *deductible*.

Dependent means a lawful *spous*e or *eligible child*. The term *dependent* does not include a person who is a *member*'s natural child for whom legal rights have been given up through adoption, or a grandchild of the *member* for whom the *member* does not have court ordered permanent guardianship or custody.

Drug Usage Guidelines means criteria and clinical treatment recommendations that are developed and approved by *our* Pharmacy and Therapeutics Committees for *us*e in evaluating requests for medications that require *approval* for coverage.

Drugs or ***Prescription Drugs*** means any of the following:

- A federal legend Drug (a medication that is required by the U.S. Food, Drug and Cosmetic Act to include a label that reads: "Caution: Federal law prohibits dispensing without a prescription");
- A *drug* that requires a prescription under state law but not under federal law;
- A compound *drug* that has more than one ingredient, at least one of which the ingredients must be a federal legend *drug* or a *drug* that requires a prescription under state law.

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

Effective Date means the applicable date Coverage under this *contract* became effective.

Eligible child means *your* or *your spouse's* child, if that child is less than 26 years of age. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption; or
4. A child for whom legal guardianship has been awarded to *you* or *your spouse*. It is *your* responsibility to notify the entity with which *you* enrolled (either the Marketplace or *us*) if *your* child ceases to be an *eligible child*. *You* mu*s*t 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 or ***Allowable 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* and a network exception (as defined below) exists or the *non-network provider* is approved or authorized by *us*, the eligible service expense is the lesser of (1) the negotiated fee, if any, that has been mutually agreed upon by *us* and the *provider* as payment in full (*you* will not be billed for the difference between the negotiated fee and the provider's charge), or (2) the amount reasonably accepted by *non-network provider* (not to exceed the *provider's* charge). In either circumstance, *you* will not be billed for the difference between the negotiated or accepted fee, as applicable, and the *provider's* charge. A "network exception" occurs when you receive *covered service* from a *non-network provider* either because there is no *network provider* accessible or available that can provide such services to you timely, or *we* determine it is in *your* best interest to receive care from a *non-network provider*.

Emergency or ***Emergent*** means a condition or *illness* which, if not immediately diagnosed and treated would result in extended or permanent physical or psychiatric impairment or loss of life, and requires the Member to seek immediate medical or psychiatric attention necessary for the relief of *acute* pain, repair of *accidental injury*, initial treatment of infection, or the relief of *illness*.

Emergency Services means health care services that are provided to a Member in a licensed medical *facility* by a *provider* after the recent onset of a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to the patient's health;
- Serious impairment to bodily functions;

Serious dysfunction of any bodily organ or part.

Emergency services do not include *us*e of a *hospital* Emergency Room or other *emergency* medical *facility* for routine services, follow-up or continuing care, unless *authorized* by the *Primary Care Provider* or *us*.

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

1. Named in the application; or
2. Whom *we* agree in writing to add as an *enrollee*.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories: Ambulatory patient services, *emergency services*, hospitalization, Maternity and newborn care, *mental health* and *Substance Use Disorder services*, including behavioral health treatment, *Prescription drugs*, Rehabilitative and *habilitative services* and devices, Laboratory services, Preventive and wellness services, and chronic disease management and pediatric services, including oral and vision care. *Essential Health Benefits* provided within this *contract* are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or annual dollar maximum.

Exacerbation means a flare-up of an existing *illness* or *injury*.

Experimental, Unproved or Investigational Procedures means medical, surgical or psychiatric procedures, treatments, supplies or pharmacological regimes not generally accepted by the medical community associated with Ambetter from Arizona Complete Health. This includes procedures, services, equipment, devices or supplies which are in a testing state or in field trials on animals or humans, or do not have required final federal regulatory approval for commercial distribution for the specific indications and methods of *us*e assessed, or are not in accordance with generally accepted standards of medical practice, or have not yet been shown to be consistently effective for the diagnosis or treatment of a Member's condition.

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

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

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

Facility or ***Facilities*** means institutions operating pursuant to state and/or federal statutes and regulations which are primarily engaged in providing *short-term* medical care and treatment of sick and injured persons. *Facility* also includes licensed institutions that provide diagnosis on an *outpatient* basis.

Family Member means a *spouse*, child, brother, sister, parent or grandparent of the *member*, or a *spouse's family member* if applicable.

Family Unit means *you* and *your dependents* covered under the *Policy*.

Federally Facilitated Marketplace or ***Health Insurance Marketplace*****,** means a resource where individuals, families, and small b*us*inesses can learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The *Federally Facilitated Marketplace* also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the *Federally Facilitated Marketplace*, and information about other programs, including *Medicaid* and the Children's Health Insurance Program (CHIP). The *Federally Facilitated Marketplace* encourages competition among private health plans, and is accessible through websites, call centers, and in-person assistance. In some states, the *Federally Facilitated Marketplace* is run by the state. In others it is run by the federal government.

Formulary is a guide to available brand and generic drugs 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 to help identify brand drugs that are clinically appropriate, safe and cost-effective treatment options, if a generic medication on the *formulary* is not suitable for your condition.

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

If no credible scientific evidence is available, then standards that are based on *physician* specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a 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 *us*e any such opinion, will be determined by *us*.

Generic Drug or ***Generic*** means a *drug* product, containing identical active ingredients to the *brand name* product, which the FDA has determined to be therapeutically equivalent to the original *brand name* product and classified as such by national pharmaceutical database companies.

Grace Period means a period of 31 days following the Premium due date during which premium payments may be paid without a lapse in Coverage, or otherwise stated under the *grace period* provision in the Provisions for Coverage section of this *Policy*.

Grievance means an expression of dissatisfaction about a matter other than an action as defined in 9 A.A.C. 34. Possible subjects for *grievances* include, but are not limited to: the quality of care or services provided; aspects of interpersonal relationships; rudeness of a *provider* or employee or failure to respect the *member's* rights.

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

Health Care Appeal means any request by *you* or *your* representative to reverse, rescind, or otherwise modify an Adverse Benefit Determination.

Health Plan means the benefits described in this *Policy* and provided by *us*.

Health Professional means a health care *provider* who is appropriately licensed, certified or otherwise qualified to deliver health services pursuant to state law and providing services within the scope of their license, and who has contracted with *us* to render *medical services* to *our* Members.

Home Health (Care) Agency means an agency or organization that is duly licensed by the appropriate licensing authority to provide skilled nursing services and other therapeutic services in the state or locality in which it is located, and operating in the scope of its license.

Home Health Care means medical care provided by a *network provider* from an approved *Home Health Care Agency* which is provided on an interim basis, or in lieu of hospitalization.

Hospice Care or ***Hospice Care Services*** 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.

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*; an *extended care facility*, nursing, rest, *custodial care*, or convalescent home; a halfway house, transitional *facility*, or Residential Treatment Facility; a Facility for wilderness or outdoor programs; or a similar establishment.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, Rehabilitation Facility, *extended care facility*, or Residential Treatment Facility, halfway house, or transitional Facility, or a patient is moved from the emergency room in a short term observation status, a *member* will not be considered in a *hospital* for purposes of this *policy*.

Hospital Services means those *medically necessary* services for registered *inpatients* which are customarily rendered in an Acute Care General *Hospital*, or psychiatric specialty *hospital*, and prescribed or directed by a *network physician*.

Illness means a sickness, disease, or disorder of a *member*.

Injury means an *accidental* bodily *injury* that is caused directly and independently of all other causes by an *accident*.

Inpatient* or *Inpatient Care means the *covered services* that a *member* who is admitted to a *hospital* receives for at least 24 consecutive hours.

Intensive Care Unit (ICU) means a separate part of a *hospital* which meets all of the following tests:

1. It provides treatment to patients in critical condition;
2. It continuously provides special nursing care or observation by trained and qualified personnel;
3. It provides life-saving equipment.

Intermittent means nursing services (including services separated in time, such as two hours in the morning and two hours in the evening) that do not exceed a total of four hours in any twenty four hour period.

Loss means an event for which benefits are payable to a *member* under this *contract*. *Expenses* incurred prior to this *contract*'s *effective date* are not covered, however, *expenses* incurred beginning on the *effective date* of insurance under this *contract* are covered.

Maintenance or ***Maintenance Care*** means services and supplies that are provided solely to maintain a condition at the level to which it has been restored or stabilized and from which level no significant practical improvement can be expected as determined by *us*.

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

Maximum out-of-pocket amount is the sum of the *deductible* amount, *prescription drug deductible amount* (if applicable), *copayment amount* and coinsurance percentage of *covered expenses*, as shown in the *Schedule of Benefits*. After the *maximum out-of-pocket amount* is met for an individual, Ambetter from Arizona 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 person's *eligible service expense*. 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*.

Medicaid means the program of medical coverage provided by the states under Title XIX of the Social Security Act, as amended by Public Law 89-97, including any amendments which may be enacted in the future.

Medical Services means those professional services of a *physician* and allied *health professionals*, including medical, surgical, diagnostic, and therapeutic services which are described in the section titled *Description of Benefits*, and which are performed, prescribed or directed by a *network physician* within the scope of their license.

Medically Necessary or ***Medical Necessity*** means health care services that a health care *provider*, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an *illness*, *injury*, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's *illness*, *injury* or disease; and
- Not primarily for the convenience of the patient, *physician*, or other health care *provider*, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's *illness*, *injury* or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of *physicians* practicing in relevant clinical areas and any other relevant factors.

The fact that a *provider* may prescribe, order, recommend or approve a treatment, service, supply or medicine does not in itself make the treatment, service, supply or medicine *medically necessary* as defined in this *policy*. The terms *medically necessary*, *medically indicated*, and *medical necessity* may be used interchangeably throughout this document.

Medicare means the federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

Member means any person enrolled under this *policy*, including *you, your spouse* or *eligible child*, for whom premium payment has been received and accepted by *our* Accounts Receivable Department. Note: *member* also includes a newborn for the first 31 days in accordance with the definition of *newborn period*.

Member Cost Share Responsibility Amount, *or* ***Member Cost Sharing,*** represents *your* deductible, *copay*, and/or *coinsurance*, but not any charges denied as *your* responsibility. *You* may be billed in cases where a claim line is denied for reasons that are *your* responsibility, such as not being eligible on the date of service,

obtaining services not covered under *your policy*, or obtaining *non-emergency services* at a non-*network provider* without *proper authorization*.

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

Mental Health Services means all services (including *hospital* stays) provided by psychiatrists, psychologists, or other mental health *providers*, including but not limited to, social workers and psychiatric nurses that meet medical criteria and are specifically stated as being covered herein.

Morbid Obesity means any of the following:

- A weight of at least two (2) times the ideal weight for frame, age, height, and sex pursuant to the National Institutes of Health (NIH) BMI
- BMI of greater than or equal to 35kg/m2 with one or more high risk co-morbidities.

Negotiated Rate means the rate that a *provider* has agreed to accept as payment in full for a Covered Charge.

Network means any *physician* group practice or organization that has entered into a written agreement with *us* for the provision of *medical services* to *members* under this *Policy*. *Our* agreement with a *network* may terminate, and the *member* may be required to select another *network*, *Primary Care Provider* or other *network provider* to be primarily responsible for providing and coordinating a *member's medical services*.

Network Chiropractor means an individual who is a licensed Doctor of Chiropractic and who is under contract to provide chiropractic services to *members* of this *Health Plan*.

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

Network Hospital means a *hospital* which has an agreement with *us* to provide *hospital services* to *members* covered under this *Policy*.

Network Pharmacy means a pharmacy that has contracted with *us* to dispense covered pharmaceutical services to *members* of this Health Plan.

Network Physician means a *physician* who has entered into an agreement, or on whose behalf an agreement has been entered into, with *us* to provide *medical services* to *members* covered under this *Policy*.

Network Provider(s) means any person or entity that has entered into a contract with Ambetter from Arizona Complete Health to provide *covered services* to *members* enrolled under this *Policy* including but not limited to, *hospitals*, specialty *hospitals*, *Urgent Care facilities*, *physicians*, pharmacies, laboratories and other *health professionals* within *our* service area.

Newborn Period means the first 31 days following birth to a covered *member* or legal adoption by a covered *member*. For the purposes of cost sharing application, newborns are considered to be enrolled *members* for the first 31 days.

Non-Network Chiropractor means a chiropractor who is not under contract to treat *members* through an arrangement with the Health Plan.

Non-Network Provider means any *provider* that has not contracted with Ambetter from Arizona Complete Health to provide health care services to *members* covered under this *Policy*.

Nurse Midwife means a person who:

- Is licensed as, or certified to practice as a *nurse midwife* and is practicing within the scope of that license; or
- Is licensed by a board of nurses as a registered nurse (R.N.) and
- Has completed a program for the preparation of *nurse midwife* that is approved by the state in which the person is practicing.

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

Outpatient* or *Outpatient Care means *covered services* that a *member* who is not an *inpatient* receives.

Over-the-Counter means any item, supply or medication which can be purchased or obtained from a vendor without a prescription.

Payor(s) means an insurer, health maintenance organization, no-fault liability insurer, self-insurer, governmental program, or other entity or program that provides or pays for health care benefits.

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

Plan means any health care entity which provides health care service and treatment Coverage.

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

Pre-Service Claim means any claim for benefits for medical care or treatment that has not yet been provided and requires the Approval of the plan in advance of the *member* obtaining the medical care.

Primary Care Provider (PCP) means a *provider* who gives or directs health care services for *you*. *PCP*'s include internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), Physician Assistant (PA), obstetrician gynecologist (ob-gyn) and pediatricians or any other practice allowed by the plan. A *PCP* supervises, directs and gives initial care and basic medical services to *you* and is in charge of *your* ongoing care.

Prior Authorization is a decision by *us* that a health care service, treatment plan, *prescription drug* or *durable medical equipment* is *medically necessary*. *We* require prior authorization for certain services before *you* receive them, except in an emergency.

Private Duty Nursing means services that are provided in a *hospital* room from a Registered Nurse (RN) or a Licensed Practical Nurse (LPN), in accordance with a *physician's* care plan. *Private Duty Nursing* services are provided by a licensed nurse that is prescribed on an *intermittent* basis while the patient is *inpatient* in a *medically necessary acute* hospitalization.

Prosthetic, Prosthetic Devices or ***Prostheses*** 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 means a licensed *physician*, dentist, podiatrist, psychologist, *hospital* or *facility*, Pharmacy, nurse practitioner, social worker holding a masters degree in social work or other licensed medical practitioner practicing within the lawful scope of their license.

Providers also include other health care professionals not specifically named in this Certificate for whom reimbursement is mandated under applicable Arizona or federal law, when licensed by the state in which services are delivered, and performing services within the scope of their license.

Qualified Autism Service Provider means either of the following: (1) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for *autism spectrum disorder*, provided the services are within the experience and competence of the person, entity, or group that is nationally certified. (2) A person licensed as a *physician* and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist and who designs, supervises, or provides treatment for *autism spectrum disorders*, provided the services are within the experience and competence of the licensee.

Qualified Autism Service Providers employ and supervise qualified autism service professionals and paraprofessionals who provide behavioral health treatment and implement services for *autism spectrum disorders* pursuant to the treatment plan developed and approved by the *Qualified Autism Service Provider*.

- A qualified autism service professional is a behavioral service provider that has training and experience in providing services for *autism spectrum disorders and is approved.*
- A qualified autism service paraprofessional is an unlicensed and uncertified individual who has adequate education, training, and experience as certified by the *Qualified Autism Service Provider*.

Qualified Travel Expenditures means transportation, room and board costs incurred while obtaining *authorized covered services* outside the Service Area in cases where it has been determined by *us* that the *authorized covered services* are not available in the Service Area. Refer to the Organ Transplant Travel Services benefit under the Description of Benefits in this *Policy* for a description of *covered services* and limitations that apply.

Referral means the request made through the *Primary Care Provider* for *authorization* of specialty services or equipment on behalf of a *member*. In order for services to be covered, *referrals* must be approved by *us*, prior to *member* receiving specialty services.

Residential Substance Use Treatment Program means a program conducted within a *Residential Treatment Center* that specializes in the evaluation and treatment of substance use disorder.
Residential Treatment Center means a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. *We* require that all contracted *Residential Treatment Centers* must be appropriately licensed by their state in order to provide residential treatment services.

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.

Routine Care includes, but is not limited to, conditions such as colds, flu, sore throats, superficial injuries, minor infections, follow-up care and preventive care. Treatment for these conditions should be sought from a *Primary Care Provider* and are not considered *emergency services*.

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*.

Short-Term means the reasonable period of time when significant, documented, continued improvement in a *membe*r's condition can be expected in a predictable period of time. A "predictable period of time" means the length of time as submitted by the *network provider* and Approved by *us* or *our* designee.

Skilled Nursing Facility means an *extended care facility* which is licensed as a *Skilled Nursing Facility* and operated in accordance with the laws of the state in which the *member* resides in.

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.

Sound Natural Teeth means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

Special Enrollment Period means individuals who experience certain qualifying events can enroll in, or change enrollment outside of the initial and annual open enrollment periods. The *effective date* of coverage depends on the Qualifying Events.

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

Specialized or ***Custom Durable Medical Equipment, Prosthetics or Orthotics*** means equipment, *prosthetics* or *orthotics* not generally considered to be the standard of care for a specific condition, disease or *injury* or made for a specific purpose not considered *medically necessary* as determined by *us*.

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

Stabilize means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to an emergency medical condition or delivery of a newborn child, including the placenta.

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

Support Devices are the rigid or semi-rigid devices, such as braces or splints, used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured body part.

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

Surrogate means an individual who, as part of a *Surrogacy Arrangement*, (a) uses her own egg that is fertilized by a donor or (b) is a gestational carrier who has a fertilized egg placed in her body but the egg is not her own.

Telemedicine Services means the mode of delivering health care services and public health via information and the interactive use of audio, video, or other electronic media 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 *telemedicine* is at a distant site. *Telemedicine services* includes synchronous interactions and asynchronous store and forward transfers, but does not include the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail.

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

Total Disability or ***Totally Disabled*** means a *member* who is prevented because of *injury* or disease from performing their regular or customary occupational duties and is not engaged in any work or other gainful activity for compensation or profit. For a *dependent*, a person who is prevented because of *injury* or disease from engaging in substantially all of the normal activities of a person of like age and good health, including any work or other gainful activity for compensation or profit.

Transcranial Magnetic Stimulation (TMS) 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.

Urgent Care means services provided for the relief of *acute* pain, initial treatment of *acute* infection, or a medical condition that requires medical attention, but a brief time lapse before care is obtained does not endanger life or permanent health. Urgent conditions include, but are not limited to, minor sprains, fractures, pain, heat exha*ust*ion, and breathing difficulties, other than those of sudden onset and persistent severity

Urgent Care Facility means any licensed *facility* that provides *physician* services for the immediate treatment only of an *injury* or disease.

Utilization Management or ***Utilization Review*** is a prior, concurrent and retrospective process whereby requests for service under this Plan are reviewed:

- For *medical necessity* and appropriateness;
- For verification that the service is a covered benefit;
- For verification where benefits have a predetermined limit that *medical services* have not been exceeded, or are being appropriately applied, or applied in a timely manner consistent with the diagnosis and treatment; and
- For verification that the *member* is eligible for services under this *Policy*.

Utilization review performed prior to receipt of services does not guarantee Coverage if other plan provisions are not satisfied (for example, *member* is not eligible on date of service).

We, ***Us***, or ***Our*** means Ambetter from Arizona Complete Health, Inc. or its designee.

You or ***Your*** means a *member* who is covered under this *policy*.

ACCESS TO CARE

UNDERSTANDING WHAT IS COVERED

Each *member* covered under this *health plan* is entitled to receive the benefits and services described in this *policy*. With the exception of preventive services, all *covered services* must be *medically necessary*. *Covered services* must be obtained from Ambetter's contracted *network providers*, except for *emergency services* as defined in this *policy*.

Ambetter reserves the right to modify benefits under this Agreement at any time. Written notice of benefit changes, including modifications to preventive benefits, will be provided to *enrollees* at least 60 days prior to the *effective date* of the change.

Although *we* encourage *you* to read this entire document to familiarize yourself with *your* health *coverage*, the following sections should be reviewed immediately upon enrollment:

- *Prior-Authorization.* This section identifies which services and supplies require *our* review before *you* receive them in order to receive the maximum reimbursement possible under *Your* Health Plan.

- *Description of Benefits*. This section describes the services and treatments, which are covered under *Your* Health Plan, including general health physicals.

- *Limitations and Exclusions*. This section identifies services and treatments that are not covered under *your* Health Plan, or are limited in coverage.

PARTICIPATING PROVIDERS

Ambetter has contracted with *physicians*, *hospitals*, *facilities* and other *health professionals* to provide *medical services* and treatments to *members* covered under this Health Plan. These *physicians*, *hospitals* and *facilities* are referred to as *network providers*.

YOUR PRIMARY CARE PROVIDER

Every *member* has the option to have a *Primary Care Provider*. These *Primary Care Providers* are sometimes referred to as a *PCP*. *Your PCP* is the person who will provide and coordinate *medical services* and treatments *you* may require while covered by *us*. At some time, *you* may need to see a *physician* who is a *specialist*. *Your Primary Care Provider* will refer *you* to one. If *you* are hospitalized, *your Primary Care Provider* will coordinate the care and services *you* need with the *hospital* and any other *physicians* who may be involved.

During regular office hours:

- Call the office and identify Yourself as an Ambetter *member*
- *Your Primary Care Provider* has a staff that can schedule an appointment or help answer *your* medical questions.

After regular office hours:

- Call the office and identify Yourself as an Ambetter *member*
- Describe the medical condition *You* are experiencing
- *Your Primary Care Provider's* office will have *your physician*, or another *health professional*, contact *you*. They will discuss the *illness* or *injury* in question and give *you* direction. Each case is different.

You may receive advice over the telephone or *you* may be asked to come into the office. In *emergency* or urgent situations, *you* may be directed to the nearest *Emergency* or *Urgent Care facility*.

- Always remember that *you* can call *your Primary Care Provider's* office 24 hours a day. *You* do not have to wait for regular office hours to obtain medical advice.

Each *member* of a family who is covered by *us* has the right to select their own *Primary Care Provider*. This means that a parent who desires to have a *Primary Care Provider* close to their office may select a different *Primary Care Provider* for their children closer to home. In addition, *you* may select a *physician* specializing in pediatrics as the *Primary Care Provider* for each child, even if the pediatric *physician* is not identified as a *Primary Care Provider*. Please make sure that *you* have selected a *Primary Care Provider* for yourself and each of *your dependents* that are enrolled under this Health Plan. Until *you* make this selection, Arizona Complete Health will designate one for *you*. Refer to *our* Provider Directory for a list of *Primary Care Providers*, or *you* can visit *our* website at https://ambetter.azcompletehealth.com/. If *you* need help in choosing a *Primary Care Provider*, call *us* Member Services at 1-888-926-5057 (TTY: 711).

CHANGING PRIMARY CARE PROVIDERS

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

NETWORK AFFILIATIONS

Your Primary Care Provider and other *health professionals* have contracted with *us* to provide *medical services* and treatments to *you*. They have contracted either individually, or through a group of Providers called a *network*. If *your Primary Care Provider* is affiliated with a *network*, *you* may be required to obtain services from *specialists* and other *providers* who belong to that *network*. If *you* are unsure whether *your Primary Care Provider* is affiliated with a *network*, check *our* Provider Directory or call Member Services.

If *your network provider* is removed from the *network* without cause, *you* will be notified of the change. If *you* are in active course of treatment, *you* may request continued treatment with the Provider until the treatment is complete, or for 90 days, whichever is shorter, at in-network *cost sharing* rates.

Active course of treatment is defined as:

- An ongoing course of treatment for a life-threatening condition;
- An ongoing course of treatment for serious *acute* condition;
- The second or third trimester of pregnancy; or
- An ongoing course of treatment for a health condition for which a treating Provider attests that discontinuing care by that Provider would worsen the condition or interfere with anticipated outcomes.

SPECIALIST PHYSICIANS

Specialist physicians may also be part of *your network*. If *your physicians* determines that *you* need care from a *specialist*, *your Primary Care Provider* will refer *you* to the appropriate *specialist* within *our network*.

Services and treatments by Specialists are covered when a *referral* is approved. Always remember that *your Primary Care Provider* is the person responsible for coordinating *your* care and will refer *you* to an

appropriate *specialist* when it is *medically necessary*. *We* do allow a few exceptions to the *referral* requirements, as described in the *Description of Benefits* section of this *Policy*.

You are not required to obtain a *referral* from a *Primary Care Provider* (*PCP*) or *us* to obtain *covered services* from a *specialist* within the *network*. *We* recommend that *you* work with *your PCP* to determine which *specialist* is right for *you*. *Your PCP* knows *your* medical history best and is the most appropriate person to help coordinate all of *your* health care needs.

Self-referrals under this *health plan* are limited to In-Network *specialists*. Services received from a *non-network provider* may be denied by *us* and *you* may be held financially responsible for the charges.

AVAILABILITY OF PROVIDERS

We cannot guarantee the continued availability of any particular *physician*, *network*, *facility* or other *health professional*. Consequently, if a *Primary Care Provider* terminates their relationship with *us*, *you* will be required to select another *Primary Care Provider*, who will be responsible for providing and coordinating *your* total health care. *Covered services* must be obtained from *network providers* who are under contract with Ambetter from Arizona Complete Health at the time *Medical Services* are received.

MEMBER COST SHARING FEATURES

MEMBER COST SHARING FEATURES

We will pay benefits for *covered services* as described in the *Schedule of Benefits* and the *covered services* sections of this *contract*. All benefits *we* pay will be subject to all conditions, limitations, and *cost sharing* features of this *contract*. *Cost sharing* means that *you* participate or share in the cost of *your* healthcare services by paying *deductible amounts*, *copayments* and *coinsurance* for some *covered services*. For example, *you* may need to pay a *copayment* or *coinsurance* amount when *you* visit *your 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 / COINSURANCE

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

INDIVIDUAL AND FAMILY DEDUCTIBLES

The Individual and Family *calendar year deductible amounts* are shown in the *Schedule of Benefits*. The *calendar year deductible* applies to the medical and *outpatient prescription drug* benefits. Once *your* payment for medical and *outpatient prescription drug covered expenses* equals the *deductible amount*, the medical and *outpatient prescription drug* benefits will become payable by *us*, subject to any additional *copayment* or *coinsurance* as described in the *Schedule of Benefits*.

Each *member* must satisfy the individual *deductible* each Year, if the Family *deductible* has not been previously satisfied in that Year, before benefits are payable by *us*. Once the Family *deductible* is met; no further Individual *deductible* for *members* of the *family unit* will have to be satisfied during the Year for benefits to be payable by *us*. Any exceptions will be shown in the *Schedule of Benefits*. All amounts applied toward the Individual *deductible* for each *member* in a *family unit* will accumulate to satisfy the Family *deductible*. Once the Family *deductible* is met, no further individual *deductibles* for covered *members* in the *family unit* will have to be satisfied during the *calendar year*.

MAXIMUM OUT-OF-POCKET

This is the total dollar amount that a *member* or *family unit* is required to pay for *covered services* during any given *calendar year maximum out-of-pockets* are determined for *covered services* only and do not apply to any *medical services* or treatments that are not *covered services*.

Individual

The *covered expenses* that *you* pay, except as described below, are counted towards the Individual *maximum out-of-pocket*. The amount of the *maximum out-of-pocket* is listed in the *Schedule of Benefits*. When

this amount is reached for an individual in a Year, *covered expenses*, except as described below, are payable at 100% for the remainder of the Year.

Family
The *covered expenses* that covered *members* in a *family unit* pay, except as described below, are counted towards the Family *maximum out-of-pocket*. The amount of the *maximum out-of-pocket* is listed in the *Schedule of Benefits*. When this individual *maximum out-of-pocket* is reached for an individual in a Family in a Year, *covered expenses* for that individual, except as described below, are payable at 100% for the remainder of the Year.

The following are not counted toward the Individual or Family *maximum out-of-pocket* and will not be paid at 100% once the *maximum out-of-pocket* is met. They will be subject to the *copayment*, *coinsurance* and/or Deductible as shown in the *Schedule of Benefits*:

1. Any percentage of *covered expenses* that a *member* must pay due to failure to follow any requirements of *Prior Authorization*.
2. Limitations and exclusions.

Refer to *your Schedule of Benefits* for *Coinsurance* Percentage and Other Limitations
The amount payable will be subject to:

1. Any specific benefit limits stated in the *contract*;
2. A determination of *eligible service expenses*; and
3. Any reduction for expenses incurred at a *non-network provider*. Please refer to the information 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* and *coinsurance* percentage, *you* are responsible for the difference between the *eligible service expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible service expense* will not apply to *your deductible amount* or *maximum out-of-pocket*.

ADJUSTED CLAIM IMPACTS TO MEMBER COST SHARE RESPONSIBILITY
Some Explanation of Benefits (EOBs) will show that a "claim payment adjustment" has occurred. Claim payment adjustments may look like claims were paid, then taken back, and possibly paid differently. Sometimes these payment adjustments appear multiple times in the same EOB. Claims payment adjustments can be at the request of the billing provider or initiated by *us* to ensure correct payments for covered services.

When adjusted claims are reflected in your EOB, they can change your *cost sharing* responsibility or impact your *out-of-pocket maximum*. *You* can track what you have paid towards *your out-of-pocket maximum* through *our* secure member portal at https://ambetter.azcompletehealth.com/ or call Member Services at 1-888-926-5057 (TTY: 711) with any questions about *your cost share* amounts.

PRIOR AUTHORIZATION

Please read this entire provision carefully. If *you* are unsure whether a service or treatment requires prior authorization, please call Ambetter from Arizona Complete Health or have your provider call Ambetter from Arizona Complete Health for additional information.

Selected medical and behavioral health services and treatments that are covered under *your health plan* require *approval* before *you* receive them in order for them to be covered by *us*. This *approval* is referred to as *prior authorization.* This means that even though a service or treatment may be a covered benefit, *prior authorization* must be obtained before the service or treatment can be received. Even those services that are determined to be *medically necessary* by *us* must have *prior authorization* in order to be covered. *Physicians* and *networks* cannot deny a service or treatment for failure to obtain *prior authorization*. Only *we* can deny *coverage* for *medical services* for failure to obtain *prior authorization*. Questions concerning *prior authorization* can be directed to *your Primary Care Provider*, or *you* can call Member Services. *Prior authorization* does not guarantee *coverage*.

Circumstances in which the service will not be covered include, but are not limited to:

- Other plan provisions are not satisfied (for example, the *member* is not enrolled or eligible for service on the date the service is received or the service is not a Covered Benefit);
- Fraudulent, materially erroneous or incomplete information is submitted; or
- A material change in the *member's* health condition occurs between the date that the *Prior Authorization* was provided and the date of the treatment that makes the proposed treatment no longer *medically necessary* for such *member*.

In the event that Company certifies the *medical necessity* of a course of treatment limited by number, time period or otherwise, a request for treatment beyond the certified course of treatment shall be deemed to be a new request.

As a general rule, please remember that, except for Emergency Services, all *Medical Services* and treatments must be provided through the direct coordination of the *Primary Care Provider* and received within the Service Area. If they are not, *your Health Plan* may not cover these services.

The following services or supplies may require *prior authorization*:

1. *Hospital confinement*s;
2. *Hospital confinement* as the result of a *medical emergency;*
3. *Hospital confinement* for *psychiatric care;*
4. *Outpatient surgeries* and *major diagnostic tests*;
5. *All inpatient services;*
6. *Extended care facility* confinements;
7. *Rehabilitation facility* confinements;
8. *Skilled Nursing Facility* confinements;
9. *Transplants;* and
10. Chemotherapy, *specialty drugs* and biotech medications.

Prior Authorization (medical and behavioral health) requests must be received by telephone, fax, or provider web portal as follows:

1. At least 14 days prior to an elective admission as an *inpatient* in a *hospital*, *extended care* or rehabilitation *facility*, or hospice *facility*.
2. At least 30 days prior to the initial evaluation for organ transplant services.
3. At least 30 days prior to receiving clinical trial services.
4. At least 14 days prior to the start of *home health care* except *members* needing *home health care* after *hospital* discharge.

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

1. For urgent *concurrent review* within 24 hours of receipt of the request.
2. For urgent pre-service, within 72 hours from date of receipt of request.
3. For non-urgent pre-service requests no longer than 14 days of receipt of the request.
4. For post-service requests, with in 30 calendar days of receipt of the request.

Except for *medical emergencies*, *prior authorization* must be obtained before services are rendered or expenses are *incurred*.

How to Obtain Prior Authorization

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 or denied.

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 prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

Prior Authorization Does Not Guarantee Benefits

Our authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *contract.*

Prior Authorization Denials

Refer to Complaint, Grievance, Health Care Appeals and External Review Procedures section of this contract for information on *your* right to appeal a denied authorization.

WHAT TO DO IN AN EMERGENCY
If *you* are faced with a medical or psychiatric *emergency*, call 911 or go to the Emergency room.

Some examples of *emergencies* include:

- *Acute* chest pain
- Severe burns
- Profuse bleeding
- Suspected poisoning
- Severe allergic reaction

Non-Emergency and *Routine Care* provided in an Emergency Facility is not covered and the *member* will be financially responsible for any Emergency room expenses incurred for such non-Emergency services. *Routine Care* is described in the *Definitions* section of this booklet.

Please refer to the *Description of Benefits* section of this booklet for a complete definition of an *emergency*. This section will also tell *you* what is covered and what *your* responsibility is to notify *us* of an *emergency* situation.

URGENT CARE SITUATIONS
Urgent Care Situations include cases of high fevers, severe vomiting, sprains, fractures, or other injuries. In such cases, call *your Primary Care Provider*. The *PCP's* office is available 24 hours a day, 7 days a week by telephone. *You* will be given direction on how to obtain care for *your* condition. All follow-up and continuing care must be provided or arranged through *your Primary Care Provider* in order to be covered by *us*.

UTILIZATION MANAGEMENT
Ambetter reviews certain requests for medical procedures, specialty consultations and hospitalizations to determine whether the treatment is *medically necessary*, as determined by *us*, and to verify that the services are covered under this Health Plan. The determination of the reviewer or professional review organization is not a substitute for the independent judgment of the treating *physician* as to the course of treatment. ***Utilization Management* decisions do not prevent treatment or hospitalization but do determine whether or how the treatment or hospitalization is covered by Ambetter.**

MEDICAL EXPENSE BENEFITS

Covered services must be furnished in connection with diagnosis *that demonstrates medical necessity* and treatment of an *illness* or *injury* (other than *covered expenses* for preventive care services, if applicable). If *we* determines that a service or supply or medication is not *medically necessary*, *you* will be responsible for payment of that service, supply or medication.

Covered services are subject to the *copayment* and/or *coinsurance* amounts, Lifetime Maximum Benefits, Maximum Benefits per Year, and other limitations as described in the enclosed *Schedule of Benefits*, and to all other provisions of this *Policy*.

Coverage under the *Policy* is limited to the most effective and efficient level of care and type of service supply or medication that is consistent with professionally recognized standards of medical practice, as determined by *us*.

HOW COVERED EXPENSES ARE DETERMINED

Ambetter from Arizona Complete Health will pay for *covered expenses you* incur under this Health Plan. As described below, *covered expenses* are based on the amount *we* will allow for *covered services you* receive from each type of Provider, not necessarily the amount a *physician* or other Provider bills for the service or supply. Other limitations on *covered expenses* may apply. See *Description of Benefits, Limitations and Exclusions*, and *your Schedule of Benefits* sections for specific benefit limitations, maximums, *Prior Authorization* requirements and surgery payment policies that limit the amount *we* pay for certain *covered services*.

HOSPITAL INPATIENT AND OUTPATIENT SERVICES

Emergency Services and the minimum *hospital* stay requirements for maternity do not require *Prior Authorization*. All other *hospital services*, whether *inpatient* or *outpatient*, must be *Prior Authorized*.

Any *member* who receives *emergency services* must contact their *Primary Care Provider* within 48 hours of admission, or as soon thereafter as is reasonably possible.

INPATIENT SERVICES

Covered Services include:

- Semiprivate room and board (private room when *medically necessary*)
- *Hospital* and *physician* services, including supplies and consultation
- *ICU*, CCU and other special care units
- Operating room and related *facilities*
- Medications and biologicals
- Diagnostic services, including x-ray and laboratory
- General nursing care (special duty nursing when *medically necessary* and *authorized*)
- Oxygen and related services
- Inhalation treatment
- *Private Duty Nursing* is provided under the direction of a *physician*-signed order, specific to an individualized plan of care implemented by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). It does not include non-skilled care, *custodial care*, respite care, or care during surgical procedures, including anesthesia.
- Surgical procedures, including anesthesia

- Meals, including special diets when *medically necessary*
- Administration of whole blood and blood plasma
- *Physician* visits
- Radiation therapy and chemotherapy
- Physiotherapy, speech therapy and occupational therapy
- *Medically necessary* services of a *physician*, including office visits and consultations, *hospital* and *Skilled Nursing Facility* visits, and visits to *your* home.

All covered surgical procedures, including the services of the surgeon or *specialist*, assistant surgeon and anesthetist or anesthesiologist, together with preoperative and postoperative care are covered.

Surgery includes surgical reconstruction of a breast incident to a mastectomy, including surgery to restore symmetry; it also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema and at least four external postoperative *prostheses*, including mastectomy bras/camisoles, subject to all of the terms and conditions of the *policy*.

Payment of benefits for surgical expenses will be reduced as set forth herein if *Prior Authorization* is not obtained for the surgery.

All *inpatient* services including *ancillary services* are subject to Arizona Complete Health *medical necessity reviews*, including *prior authorization*, concurrent and post service payment reviews. Any service or payment denials will include *health care appeal* and *grievance* process and contact information.

OUTPATIENT SERVICES INCLUDING AMBULATORY SURGICAL FACILITIES

Covered Services include:

- Medications and biologicals
- Surgical procedures, including anesthesia
- Therapeutic services including chemotherapy, radiation therapy and inhalation treatment
- Diagnostic services, including x-ray and laboratory
- Oxygen and related services
- *Emergency Services* as defined in this *Policy*
- Administration of whole blood and blood plasma

All *outpatient* services including *ancillary services* are subject to Arizona Complete Health medical necessity reviews, including prior authorization and post service payment reviews. Any service or payment denials will include *health care appeal* and *grievance* process and contact information.

OFFICE VISITS
Covered Services include:

- Office visits to *physicians*, including *specialists*
- Treatment for an *injury* or *illness*
- Allergy testing, antigen administration, desensitization treatment, allergy treatment and allergen administration in accordance with accepted medical practice, or as otherwise determined to be *medically necessary*.
- An annual flu shot, when received in the office of the *Primary Care Provider* at a *network pharmacy* participating in the vaccine network, or at an affiliated flu shot clinic sponsored by the *member's Primary Care Provider*.

Note additional services (including but not limited to x-rays and/or lab testing services) that are performed within an office visit setting may be subject to additional *member cost sharing* in accordance with the *Schedule of Benefits*. *Eligible service expenses* for preventive care services do not require *member cost sharing*.

Additionally, some *providers* (e.g. *Primary Care Providers*, *specialist*) may operate out of a *hospital* or *facility*, note that applicable *copayments* or *coinsurance* for an office visit may not cover any charges that the *hospital* or *facility* bills and *you* may be responsible for these charges.

ROUTINE PHYSICAL EXAMINATION
One routine physical examination (including psychological examination or drug screening) per *calendar year*, requested by the *member* without medical condition indications is covered. However, filling out forms related to the physical exam is not covered.

A routine examination is one that is not otherwise medically indicated or *physician* directed and is obtained for the purposes of checking a *member's* general health in the absence of symptoms or other non-preventive purposes. Examples include examinations taken to obtain employment, or examinations administered at the request of a third party, such as a school, camp, or sports organization.

PREVENTIVE CARE, EXAMINATIONS AND IMMUNIZATIONS
The *coverage* described below shall be consistent with the requirements of the Affordable Care Act. Whether something is preventive is determined by the diagnosis submitted by the *provider*. Preventive Care can include the following:

- Preventive health exams
- Well baby care for 47 months
- Immunizations
- Hearing screening
- Vision screening
- Gynecological examinations
- Flu shot
- Womens Preventive Services include, but are not limited to:
    - Screening for gestational diabetes,
    - Human papillomavirus (HPV) DNA testing for women 30 years and older,
    - Sexually-transmitted infection counseling;
    - Human immunodeficiency virus (HIV) screening and counseling;

- FDA-approved contraception methods and sterilization procedures, and contraceptive counseling for women with reproductive capacity;
- Breastfeeding support, supplies, and counseling (One breast pump and the necessary supplies to operate it (as prescribed by *your physician*) will be covered for each pregnancy at no cost to the *member*. *We* will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it. Breast pumps can be obtained by contacting Member Services at 1-888-926-5057 (TTY: 711); and
- Interpersonal and domestic violence screening and counseling.

- Colorectal Cancer Screening: Screening colonoscopy and sigmoidoscopy procedures, related including anesthesia services (for the purposes of colorectal cancer screening) will be covered under the preventive care services. Diagnostic endoscopic procedures (except screening colonoscopy and sigmoidoscopy), performed in an *outpatient facility* require the *copayment* or *coinsurance* applicable for *outpatient facility* services.
- Preventive Lab and X-ray
- Counseling Services: counseling for alcohol misuse, smoking cessation, breastfeeding/lactation, depression/psychological, genetic, healthy diet/ nutrition, obesity in adults and children, preventative medication, sexually transmitted infections, and Tobacco use.
- Preventive medications (including smoking cessation medications)

Additional recommended preventive care services include the following:

- United State Preventive Services Task Force (USPSTF)recommended type "A" and "B" services
- Immunizations and inoculations as recommended by the Advisory Committee on immunization Practices of the Center for Disease Control (CDC)
- Evidence-informed preventive care and screenings provided for in HRSA guidelines for infants, children, adolescents and women;
- Women's health care services as supported by HRSA guidelines;
- Other USPSTF recommendations for breast cancer screening, mammography and prevention.
- Prostate specific antigen (PSA) screening and digital rectal examination (DRE) are covered annually if the following criteria is met:
  1. If *you* are under 40 years of age and are at high risk because of any of the following:
     a. Family history (i.e., multiple first-degree relatives diagnosed at an early age)
     b. African-American race
     c. Previous borderline PSA levels
  2. If *you* are age 40 and older.

Preventive physical examinations and immunizations will be covered when obtained from or through *your Primary Care Provider* according to the guidelines and policies adopted by *us*. This Agreement will not provide less than the minimum benefits required by state and federal laws. Additional examinations and immunizations will be covered if determined to be *medically necessary* by *your Primary Care Provider*, subject to the Limitations and Exclusions listed herein.

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

AMBULANCE SERVICES
Covered Services include:

- *Emergency* transportation from the site of an *accidental* injury or *acute illness* to the nearest *facility* capable of providing appropriate treatment.
- Air or water evacuation will be considered *medically necessary* if the patient's condition is of an *emergency* nature, the location where the *accidental injury* and/or *illness* occurred is inaccessible by ground vehicles, or transport by ground *ambulance* would be detrimental to the patient's health.
- Transportation between *hospitals* or between a *hospital* and skilled nursing or rehabilitation *facility* when *authorized* by Ambetter from Arizona Complete Health.

Covered Services for ground, water or air *ambulance* travel must be provided by a duly licensed vehicle specifically designed and equipped for transporting the sick and/or injured.

Covered Services do not include transportation for non-*emergent* treatment unless *authorized* by *us*.

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* unless *prior authorization* is approved before services are rendered to the *member*.
3. *Ambulance* services provided for a *member's* comfort or convenience.
4. Non-*emergency* transportation excluding *ambulances* (for example- transport van, taxi).

AUTISM SPECTRUM DISORDER
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*.

BARIATRIC SURGERY AND RELATED COVERED SERVICES
Covered Services include *inpatient* bariatric surgery and gastric bypass surgery, including lap banding adjustments, for the treatment of Morbid Obesity that are *medically necessary* and not *experimental or investigational*. These *covered services* must be *authorized* by *us* in accordance with *our* evidence based criteria for this intervention contained in *our* Medical Policy on Bariatric Surgery which can be found at https://ambetter.azcompletehealth.com/ under the medical policies link.

In addition, the following criteria must be met:
1. The patient must have a body-mass index (BMI) ≥35.
2. Have at least one co-morbidity related to obesity.
3. Previously unsuccessful with medical treatment for obesity.

The following medical information must be documented in the patient's medical record:
- Active participation within the last two years in one *physician* supervised weight-management program for a minimum of six months without significant gaps.
- The weight-management program must include monthly documentation of all of the following components:
  a. Weight
  b. Current dietary program
  c. Physical activity (e.g., exercise program)

We apply evidence based medicine, and in as much develops national medical policies to define *medical necessity*. At a minimum, the following procedures are included: laparoscopic sleeve gastrectomy (LSG), open roux-en-y gastric bypass (RYGBP), laparoscopic adjustable gastric banding (LAGB), open biliopancreatic diversion with duodenal switch (BPD/DS) and laparoscopic biliopancreatic diversion with duodenal switch (BDP/DS).
- Surgery will be considered *medically necessary* for adolescent ages 13 to 18 years of age when criteria is met.

In addition, the procedure must be performed at a *network facility*.

CHIROPRACTIC SERVICES
Members may self-refer to a contracted Doctor of Chiropractic. Coverage is provided for *medically necessary* Chiropractic Services.

Covered Services are those within the scope of chiropractic care which are necessary to help *members* achieve the physical state enjoyed before an *illness* or *injury*, and which are determined to be *medically necessary* and generally furnished for the diagnosis and/or treatment of neuromusculoskeletal conditions associated with an *injury* or *illness*, including:

- Chiropractic manipulations, adjustments and physiotherapy
- Diagnostic radiological services generally provided by *network chiropractors*
- Examination and treatment for the *aggravation* of an *illness* or *injury*
- Examination and treatment for the *exacerbation* of an *illness* or *injury*

CLINICAL TRIALS
Routine patient costs for items and services furnished in connection with participation in approved clinical trials are covered as required by state and federal law. *We* will not exclude, limit or impose special condi-

tions on such coverage and *we* will not include provisions that discriminate against an individual on the basis of the individual's participation in an approved clinical trial. *You* must pay any *deductibles, copayments* or *coinsurance* that apply to the items and services whether or not *you* receive the items and services in connection with Clinical Trial. *Prior Authorization* is required. The following provisions apply:

- Routine patient costs include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include:
    a. The cost of Investigational services, drugs or devices, whether or not *you* receive the items and services in connection with clinical trial;
    b. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
    c. The cost of any non-health services;
    d. The cost of managing research; or
    e. Items or services that would not otherwise be covered
- Approved clinical trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening condition and is approved or funded by at least one of the following:
    a. One of the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, or the Centers for Medicare and Medicaid Services, the United States Department of Defense, or the United States Department of Veterans Affairs;
    b. Supported by a cooperative group or center of any of the entities described above;
    c. The Federal Drug Administration (FDA) in the form of an investigational new drug application or if the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
    d. A qualified research entity that meets the criteria of the NIH for grant eligibility; or
    e. A panel of qualified recognized experts in clinical research within academic health institutions in this state.

For purposes of clinical trials, the term "life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

DENTAL SERVICES

Emergent dental services under this *health plan* are limited to services and treatments which are received in connection with an *injury* or as a direct result from a *congenital defect*.

Services are covered under the *medical* portion of *your health plan* when it is determined to be related to a medical condition or *injury* and are determined to be *medically necessary* and include:

- Services to treat *sound natural teeth* damaged as a result of an *accident*.
- The reduction or manipulation of fractures of facial bones including the jawbone and supporting tissues due to an *accidental injury*.
- Oral surgery for the excision of lesions, cysts, or tumors.
- Reconstruction or repair of the palate or cleft lip.
- Orthognathic treatment/surgery, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral) are covered if approved as *medically necessary*

Dental Services under this *health plan* do not include:

- Preventive, routine or general care of teeth or dental structures.
- Extraction of impacted or abscessed teeth and services related to malocclusion or malposition of the teeth or jaw.
- Dental splints, dental implants, dental *prostheses* or dentures.
- General anesthesia unless required due to hazardous medical conditions
- Dental applications and orthodontia

DIABETIC CARE MANAGEMENT

The following is covered in relation to *members* who have been diagnosed with diabetes:

- Diabetes *outpatient* self-management training and education, including a wellness health coaching program that guides an individual to change unhealthy behaviors and adopt positive lifestyle changes in order to promote the life-long practice of good health behavior. Refer to the *Schedule of Benefits* Health under Health/Education and Disease Management for applicable *copayment*, *coinsurance* or *deductibles*.
- Supplies and equipment related to Diabetes Management as described in the *outpatient prescription drug* Benefit and Diabetic Supplies, Equipment and Devices provision of this section.
- Nutritional counseling services are covered and not subject to the lifetime limit as shown in the Nutritional Counseling Services provision of this section.
- Routine foot care in connection with the treatment of diabetes.
- Self-referral once each Year to an eye care *specialist* for the purpose of receiving an eye exam for the detection of eye disease as described in the Vision Services provision of this section.

DIABETIC EQUIPMENT, SUPPLIES AND DEVICES

Diabetic supplies are covered when *medically necessary*. The following are specific requirements for *coverage*:

- Diabetic supplies must have a written prescription from a *network provider*, when *medically necessary*.
- Refills are covered only when *authorized* by a *network provider*, when *medically necessary*.
- Covered supplies and equipment must be obtained from a *network provider* unless otherwise *authorized* by *us*.
- Plan approved standard blood glucose monitors are covered for both insulin-dependent and non-insulin dependent *members* when necessary for medical management as determined by *us* in consultation with *your physician*. Blood glucose monitors require a written prescription from a *physician* and must be obtained at a *network pharmacy*.
- Plan approved blood glucose monitors for the legally blind are covered when *medically necessary* and the *member* has been diagnosed with diabetes. Blood glucose monitors require a written prescription from a *physician* and must be obtained at a *network pharmacy*.

The following are examples of Diabetic supplies that are covered when they meet the specific requirements for *coverage*:

- Glucose test strips
- Visual reading testing strips
- Urine testing strips
- Insulin aids (when *medically necessary*)

- Glucagon
- Drawing up devices (syringes) and monitors for the visually impaired
- Preferred Insulin vials/pens
- Insulin cartridges for both the legally blind and the able seeing (requires *Prior Authorization*)
- Insulin and insulin pumps
- Lancets and Automatic lancing devices
- Spacers and holding chambers for inhaled medications
- Inhalers (nasal or oral)
- Injection aids

The following diabetic equipment is covered under the Durable Equipment Benefit:
- Podiatric appliances necessitated by a diabetic condition.
- Foot *orthotics* are covered for the treatment of diabetes.

DIALYSIS SERVICES
Medically necessary acute and chronic dialysis services are covered benefits unless other coverage is primary, such as *Medicare* for dialysis. There are two types of treatment provided you meet all the criteria for treatment. *You* may receive hemodialysis in an in-network dialysis facility or peritoneal dialysis in *your* home from a *network provider* when you qualify for home dialysis.
Covered Services include:
- Services provided in an outpatient dialysis facility or when services are provided in the home.
- Processing and administration of blood or blood components.
- Dialysis services provided in a hospital.
- Dialysis treatment of an acute or chronic kidney ailment which may include the supportive use an artificial kidney machine.

After *you* receive appropriate training at a dialysis facility *we* designate, *we* cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis. Coverage is limited to the standard item of equipment or supplies that adequately meets *your* medical needs. *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 (DME), Prosthetics, and Orthotic Devices
The supplies, equipment and appliances described below are *covered services* under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is *medically necessary* in *your* situation or needed to treat *your* condition, reimbursement will be based on the maximum allowable amount for a standard item that is a *covered service*, serves the same purpose, and is *medically necessary*. Any expense that exceeds the maximum allowable amount for the standard item which is a *covered service* is *your* responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates *your* condition. Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:
1. The equipment, supply or appliance is a *covered service*;
2. The continued use of the item is *medically necessary*; and

3. There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

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

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

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

Durable Medical Equipment

The rental or purchase of durable medical equipment prescribed by a *physician* or other provider. *Durable medical equipment* is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. The determination to either purchase or rent equipment expected to cost over $1,000 will be made by the plan. The cost for delivering and installing the equipment are *covered services*. Payment for related supplies is a *covered service* only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the *member*; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered services may include, but are not limited to:
1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for IV fluids and medicine.
5. Glucometer.
6. Tracheotomy tube.
7. Cardiac, neonatal and sleep apnea monitors.
8. Augmentive communication devices are covered when *we* approve based on the *member's* condition.

Exclusions:
Non-covered items may include but are not limited to:
1. Air conditioners.
2. Ice bags/coldpack pump.
3. Raised toilet seats.
4. Rental of equipment if the *member* is in a facility that is expected to provide such equipment.
5. Translift chairs.

6. Treadmill exerciser.
7. Tub chair used in shower.

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

Covered services may include, but are not limited to:
1. Allergy serum extracts.
2. Chem strips, glucometer, lancets.
3. Clinitest.
4. Needles/syringes.
5. Ostomy bags and supplies except charges such as those made by a pharmacy for purposes of a fitting are not *covered services*.
6. Compression garments when used as treatment for Lymphedema.

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

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

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

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

4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are *covered services*. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the *member* selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (the first one following cancer treatment or second or third degree burns, not to exceed one per year).

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. Artificial heart implants.
5. Wigs (except as described above following cancer treatment or second or third degree burns).
6. Penile prosthesis in *members* suffering impotency resulting from disease or injury.

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

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

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

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

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

1. Orthopedic shoes (except therapeutic shoes for diabetics).
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under medical supplies).
4. Garter belts or similar devices.
5. Foot *orthotics*, except when attached to a permanent brace or when prescribed for the treatment of diabetes, or any of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation.

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

EMERGENCY SERVICES
If *you* are faced with a medical or psychiatric Emergency, call 911 or go to the Emergency room.

Emergency/Emergent is defined as a condition or *illness* which, if not immediately diagnosed and treated:

- Would result in extended or permanent physical or psychiatric impairment or loss of life; and
- Requires the *member* to seek immediate medical or psychiatric attention necessary for the relief of *acute* pain, repair of *accidental injury*, initial treatment of infection or the relief of *illness*.

Examples of *emergency* include a severe burn, profuse bleeding, a suspected heart attack, sudden *acute* pain in the chest, a severe allergic reaction or suspected poisoning.

Emergency Services means health care services that are provided to a *member* in a licensed *hospital* Emergency Facility by a *provider* after the recent onset of a medical or psychiatric condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical or psychiatric attention could reasonably be expected to result in any of the following:

- Serious jeopardy to the patient's health;
- Serious impairment to bodily functions;
- Serious disfigurement of the patient;
- Serious dysfunction of any bodily organ or part;
- In case of a behavioral condition, placing the health of the patient or other persons in serious jeopardy; and
- In the case of a pregnant woman who is having contractions with inadequate time to safely transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or unborn child.

***Emergency Services* do not include use of a Hospital Emergency room or other *emergency* medical *facility* for routine *medical services*, or follow-up or continuing care. The *member* will be financially responsible for any Emergency room expenses for any non-*Emergency* Services as determined by Ambetter.**

Emergency Services are provided 24 hours a day, 7 days a week, worldwide.
Emergency Services:

- Do not require *Prior Authorization*.
- Include an initial medical or psychiatric screening examination and any immediate treatments or services to stabilize a condition. Additional treatments or services may be retrospectively reviewed for *medical necessity*.
- Require the *member* to notify the *Primary Care Provider* within 48 hours after *emergency services* are provided by a *non-network provider*, or as soon thereafter as is medically possible. If admitted to a non-contracted *inpatient facility*, *we* may transfer the *member* to a *network hospital* for continued care if it is medically appropriate.
- Require the *member* to provide full details, including medical or psychiatric records of *emergency services* rendered by a *non-network provider*, if requested by this Health Plan. Costs associated with *emergency services* will be reimbursed only after *we* receive and review the *emergency* medical or psychiatric records and determine that such services were *medically necessary*.

Emergency Services Outside the Service Area
Members who sustain an *injury* or become ill while away from the Service Area may receive *emergency services* as provided herein. Benefits are limited to conditions that require immediate attention.

Emergency Services outside of the Service Area do not include:

- Elective or specialized care.
- Non-*emergent*, continuing, routine or follow-up care.

NON-EMERGENCY SERVICES
If *you* are traveling outside of the Arizona 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 Arizona by searching the relevant state in *our provider* directory at https://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.

FAMILY PLANNING SERVICES (CONTRACEPTION AND VOLUNTARY STERILIZATION)
Covered family planning services include:

- Medical history;
- Physical examination;
- Related laboratory tests;
- Medical supervision in accordance with generally accepted medical practice;
- Information and counseling on contraception;
- Implanted/injected contraceptives; and
- After appropriate counseling, *medical services* connected with surgical therapies (vasectomy or tubal ligation).

- Abortions that are determined to be *medically necessary* to save the life of the *member*, or due to rape, incest, life-endangerment, or necessary to avert substantial and irreversible impairment of a major bodily function of the *member* having the abortion are covered.
- Diagnostic genetic testing when determined to be *medically necessary* and *Prior Authorized* by *us*
- Tubal ligations
- Vasectomies
- Contraceptive methods and contraceptive counseling, as supported by the Health Resources and Services Administration (HRSA) guidelines, are covered under the Preventive Care benefit. FDA-approved contraceptive drugs and devices are covered through a *network pharmacy* under the *outpatient prescription drug* Benefit.

Contraceptives
Refer to the *Schedule of Benefits* and *outpatient prescription drug* benefit for a description of *covered services*.

Genetic Testing
- Diagnostic genetic testing is covered when determined to be *medically necessary* and *authorized* by *us*.
- Genetic testing, amniocentesis, ultrasound, or any other procedure required solely for the purposes of determining the sex of a fetus is not covered.

Sterilization Procedures
- Sterilization procedures, including tubal ligation and vasectomy are covered. *Copayment* and/or *coinsurance* will correspond to the charge associated with the *facility* in which services are received. Preventive sterilization of *members* is covered under the Preventive Care benefit, subject to the applicable *copayment* and/or *coinsurance* listed under the Preventive Care section.

FERTILITY PRESERVATION
Medically necessary services and supplies for standard fertility preservation treatments are covered when a cancer treatment may directly or indirectly cause iatrogenic infertility. Iatrogenic infertility is infertility that is caused by a medical intervention, including reactions from prescribed drugs or from medical or surgical procedures that may be provided for cancer treatment.

Exclusions and Limitations: Services and supplies for gamete or embryo storage, use of frozen gamete or embryos to achieve future conception, pre-implantation genetic diagnosis, donor egg, sperm or embryos and/ or gestational carriers.

GENDER AFFIRMING SERVICES
Medically necessary gender affirming services, including, but not limited to, psychotherapy, pre-surgical and post-surgical hormone therapy, and surgical services (e.g., such as genital surgery and mastectomy), for the treatment of gender dysphoria are covered.

Services not *medically necessary* for the treatment of gender dysphoria are not covered. Gender affirming surgical services must be performed by a qualified *provider* in conjunction with gender affirming surgery or a documented gender affirming surgery treatment plan.

HABILITATIVE SERVICES
Coverage for *habilitative services* and/ or therapy is limited to *medically necessary* services that help a person keep, learn, or improve skills and functioning for daily living, when provided by a Plan contracted *physician*, licensed physical, speech or occupational therapist or other contracted *provider*, acting within the scope of their license, to treat physical and mental health conditions, subject to any required *authorization* from the Plan or the *member's* Physician Group. Examples include therapy for a child who is not 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.

Examples of health care services that are not habilitative include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, *custodial care*, or education services of any kind, including, but not limited to, vocational training**.**

HEARING SERVICES
Covered Services include:

- Hearing screenings to determine the presence of hearing loss and/or to diagnose and treat a suspected disease or *injury* to the ear.
- Treatment for a disease or *injury* to the ear.
- Cochlear implants when *medically necessary*.
- New or replacement hearing aids no longer under warranty (*Prior Authorization* required).
- Cleaning or repair.
- Batteries for cochlear implants.

Covered Services do not include:

- Hearing aid batteries (except those for cochlear implants) and chargers are not covered.

HOME HEALTH CARE SERVICES
Covered services and supplies for home healthcare when *your physician* indicates you are not able to travel for appointments in a medical office, includes *medically necessary in-network care* provided at the *member's* home and includes the following:

- *Covered services* must be provided by an Ambetter contracted *Home Health Care Agency*.
- *Coverage* is limited to *medically necessary* patient care pursuant to guidelines, frequency, duration and level *authorized* by *us*.
- *Covered services* include nursing care under the supervision of a registered nurse and rehabilitative therapy and/or IV therapy, when prescribed, *authorized* or directed by the *Primary Care Provider* and *authorized* by *us*.
- *Covered services* are limited to part-time and *intermittent* patient care that is determined to be *medically necessary*.

Covered Services do not include:

- Housekeeping services
- Services of a person who resides in the *member's* home
- *Custodial care*, rest cures, respite care and home care that is or can be performed by *family members* or non-medical personnel
- Services of a person who qualifies as a *family member*
- Services of an unlicensed person.

HOSPICE CARE SERVICES
Members who are diagnosed as having an *illness* giving them a life expectancy of 6 months or less, may request *hospice care*. All *hospice care* must be provided by a licensed Participating hospice and include *Inpatient* and *outpatient* care related to the terminal condition and family counseling. *Hospice care* will continue only while the *member* is under the direct and active medical supervision of a *network physician* for a condition that necessitates *hospice care. Hospice care* may require *prior authorization* by *us*.

Hospice Care providers must be able to provide:

- Licensed nursing care
- Medical supplies
- Medications
- *Physician* services
- *Short-term inpatient* care
- Medical appliances
- Homemaker services
- Care for *acute* and chronic symptom management
- Care for pain control
- Physical and/or respiratory therapy
- Medical social services
- Home health services
- Services of volunteers
- Services of a psychologist, social worker or family counselor for individual and family counseling.

A *member* who elects *hospice care* is not entitled to services and supplies for curative or life prolonging procedures during the time that the Hospice election is in effect. A *member* may revoke a Hospice election at any time.

INFERTILITY SERVICES
Services associated with infertility are limited to diagnostic services rendered for infertility evaluation. Refer to the *Limitations and Exclusions* section of this *Policy* for more detail on non-covered infertility services.

MAMMOGRAMS
Mammograms are *covered services* as listed below, when requested by a *network physician*. A suggested schedule for preventive care is listed below:

- One baseline mammogram for *member*s between the ages of 35 and 39 years.
- One mammogram each year for *members* who are 40 years of age or older or more frequently if recommended by a *network physician*.
- Such other mammography screenings as are determined to be *medically necessary* for a *member* considered "at risk," as determined by *us* and requested by a *network physician*.

MATERNITY CARE SERVICES
Medically necessary services and supplies furnished in connection with pregnancy and childbirth are covered.

Covered Services include:

- Prenatal and post-partum care
- Birth services, including delivery room, *birthing centers*, anesthesia and surgical procedures
- Ultrasound
- Anesthesia
- Injectables
- Special procedures such as caesarian section
- Prenatal diagnostic procedures in case of high risk pregnancy or as otherwise *medically necessary*
- *Complications of Pregnancy* as defined in this *Policy*
- X-ray and laboratory services
- Surgical procedures
- Breastfeeding support, supplies, and counseling as supported by the Health Resources and Services Administration (HRSA) guidelines, are covered under the Preventive Care benefit listed in the *Schedule of Benefits*.
- Prenatal screenings as outlined in the USPSTF recommendations A&B are covered under the Preventive Care benefit listed in the *Schedule of Benefits*.
- Diagnostic genetic testing is covered when determined to be *medically necessary* and *authorized* through the *physician*, or referring *specialist*.
- Arizona newborn screenings

NOTE: To continue *coverage* after the first 31 days, the newborn must have an Enrollment Application submitted within 60 days of the date of birth. Failure to *enroll* a newborn within 60 days following the date of birth will terminate coverage at the end of the initial 31 day period. For continued *coverage* of the newborn beyond the first 31 days following birth, *members* are required to complete the *enrollment* process for the newborn by the 60th day of birth. For additional information regarding premium due dates, please reference the Enrollment of Newborn, Adopted Child or Child Placed for Adoption provision of this *contract*. Newborn *enrollees* have 30 calendar days from the date of *enrollment* to have a *Primary Care Provider* designated and receive a *member* identification card.

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

Duty to Cooperate. *Members* who are a *surrogate* at the time of enrollment or *members* who agree to a *surrogacy arrangement* during the plan year must, within 30 days of enrollment or agreement to participate in a *surrogacy arrangement*, send *us* written notice of the *surrogacy arrangement* in accordance with the notice requirements set forth in General Provisions herein. In the event that a *member* fails to comply with this provision, *we* reserve *our* right to enforce this EOC on the basis 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*.

Travel Outside of the Service Area

Expectant *members* who have reached 32 weeks gestation are encouraged to discuss any travel arrangements outside of the Service Area with their *Primary Care Provider*. Prenatal visits or elective care received outside of Ambetter's Service Area are not covered unless *authorized* by *us*. *Emergency services* received outside the Service Area are limited to conditions that require immediate attention.

Minimum Hospital Stay Requirements. *Hospital* length of stay for the mother and newborn following a covered delivery will be at the discretion of the treating *physician* in consultation with the child-bearer. *Hospital* benefits for the child-bearer and newborn will not be restricted to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarian section, if ordered by the treating *physician*. *Providers* will not be required to obtain *Prior Authorization* for such lengths of stay. These provisions do not prohibit lengths of stay of less than the minimum otherwise required when the attending *physician*, in consultation with the child-bearer, makes a decision for early discharge.

Other maternity benefits which may require *prior authorization* by *us* 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. Complication of pregnancy; or
5. Hospital stays beyond the 48 hours following a normal vaginal delivery, or more than 96 hours following a caesarian section if there are *medically necessary* reasons associated with maternity care.

Newborn Charges

Medically necessary services, including *hospital services*, are provided for a newborn child of the *member* immediately after birth. In addition, *medical services* for the newborn child shall be provided for the first 31 days following birth. Starting from the date of birth through the first 31 days the newborn maintains an independent *member cost sharing* responsibility including *deductible*, *copayments* and *coinsurance* when applicable. For continued *coverage* of the newborn beyond the first 31 days following birth, *members* are required to complete the *enrollment* process for the newborn and provide premium payment as of the effective date of *enrollment* of the newborn. For additional information regarding premium due dates, please reference the Enrollment of Newborn, Adopted Child or Child Placed for Adoption provision of this *contract*. . Each type of *covered service* incurred by the newborn child will be subject to the *member cost sharing* amount listed in the *Schedule of Benefits.*

Newborn coverage and *cost sharing* does not include a person who is a *member*'s natural child for whom legal rights have been given up through adoption, or a grandchild of the *member* for whom the *member* does not have court ordered permanent guardianship or custody.

Medically necessary coverage and *cost sharing* for a newborn may be extended beyond the first 31 days without enrolling in the plan as appropriate including:

- The mother is discharged from the hospital AND the newborn child remains hospitalized; OR
- The newborn child is readmitted

The below information details newborn statuses and *coverage*. Please contact Member Services at the number on the back of *your* ID card for assistance with understanding *your* specific situation and applicable *coverage*.

For newborns discharged within the initial 31 days of *coverage*, the newborn will be covered by *us* and has *member cost sharing* that applies to total annual *family unit* cost sharing.

For newborns discharged after the initial 31 days of *coverage* and not readmitted, the newborn will continue to be covered by *us* through the date of discharge. Newborns continue to have *member cost sharing* that applies to total annual *family unit* cost sharing.

For newborns discharged and readmitted during the first 31 calendar days from the date of birth, the newborn will continued to have *coverage* by *us* through the date of discharge (*coverage* will be extended beyond the initial 31 days through the date of discharge in this scenario). Newborns continue to have *member cost sharing* that applies to total annual *family unit cost sharing*.

For newborns discharged during the first 31 days, and readmitted after the initial 31 days of *coverage*, the newborn would not continue to be automatically covered by *us*. To continue *coverage* after the first 31 days, the newborn must have an Enrollment Application submitted within 60 days of the date of birth. Failure to enroll a newborn within 60 days following the date of birth will terminate *coverage* at the end of the initial 31 day period. The continued *coverage* of the newborn after the initial 31 day period is subject to *our* receipt of premium payment for such newborn.

MENTAL HEALTH & SUBSTANCE USE DISORDER - INPATIENT AND OUTPATIENT SERVICES
The *coverage* described below is intended to comply with requirements under the Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Mental health services will be provided on an *inpatient* and *outpatient* basis and include treatable mental disorders. These disorders affect the *member's* ability to cope with the requirements of daily living. If *you* need *mental health* and/or *substance use disorder* treatment, *you* may choose any *provider* participating in *our* behavioral health and *substance use provider network* and do not need a *referral* from *your PCP* in order to initiate treatment. *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*, including *autism spectrum 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 current version of the International Statistical Classification of Diseases and Related Health Problems (ICD).

When making *coverage* determinations, *our* behavioral health and *substance us*e coverage utilizes established level of care guidelines and *medical necessity* criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. *Our* behavioral health and *substance use* program utilizes "InterQual" criteria for mental health determinations and American Society of Addiction Medicine (ASAM) criteria for *substance us*e 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 Services
Covered Services Include:

- *Inpatient* detoxification treatment;
- Observation;
- *Crisis* Stabilization;
- *Inpatient* Rehabilitation;
- *Residential treatment facility for mental health and substance use;*
- Inpatient Psychiatric Hospitalization; and
- Electroconvulsive Therapy (ECT).

Outpatient Services
Covered services include, but are not limited to:

- Individual and group mental health evaluation and treatment;
- *Outpatient* services for the purpose of monitoring drug therapy;
- *Outpatient* detoxification programs;
- Medication management services;
- Psychological and Neuropsychological testing and assessment;
- Applied Behavioral Analysis;
- Telemedicine;
- Partial Hospitalization Program (PHP);
- Intensive Outpatient Program (IOP);
- Mental health day treatment;
- Electroconvulsive Therapy (ECT);
- Transcranial Magnetic Services; and
- 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.

Ambetter has a policy to address any network exception needs. Qualified instances in which Ambetter will make a network exception include:

- There is no *provider* in *our network* that is accessible or available that can provide *you covered services* in a timely manner; or
- *We* review *your* case and determine that it is the best interest of *your* care for *you* to see a *provider* outside of *our network*.

NUTRITIONAL COUNSELING SERVICES
Nutritional evaluation and counseling from a *network provider* is covered when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition, including but not limited to:

- Morbid obesity
- Diabetes
- Cardiovascular disease
- Hypertension
- Kidney disease
- Eating disorders

- Gastrointestinal disorders
- Food allergies
- Hyperlipidemia

Services for the purpose of diet control and weight reduction are not covered, unless required by a specific condition of disease etiology. Services not covered include but not limited to:

- Intra oral wiring
- Gastric balloons
- Dietary formulae
- Hypnosis
- Cosmetics
- Health and beauty aids

ORAL AND MAXILLOFACIAL SURGERY

Covered under this benefit:

- The reduction or manipulation of an *acute* fracture of facial bones including the jawbone and supporting tissues due to an *accidental injury*
- Oral surgery for the excisions of lesions, cysts or tumors
- Reconstruction or repair of the palate or cleft lip

Not Covered:

- Any treatment for arthroplastic surgery
- Any services related to malocclusion or malposition of the teeth or jaw
- Oral implants and transplants

OUTPATIENT IMAGING AND TESTING SERVICES

Covered Services include:

- CT
- MRI/MRA
- PET/SPECT
- BEAM (Brain Electrical Activity Mapping)
- ECT (Emission Computerized Tomographam)

Copayments and *coinsurance* may be different depending on whether the services are received at a *physician's* office, or a *hospital*, *outpatient* Surgery Facility or *Ambulatory Surgical Facility*. *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 *member 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).

OUTPATIENT PRESCRIPTION DRUG BENEFIT

This benefit applies only to Prescription Drugs that are prescribed on an *outpatient* basis.

Preventive Pharmacy medications require a prescription and are limited to *prescription drugs* and *over-the-counter* medications that are determined to be preventive as recommended by the United States Preventive Services Task Force (USPSTF) A and B recommendations, as well as FDA approved *over-the-counter* contra-

ceptives for women when prescribed by a *provider*. A listing of these medications may be identified at the following USPSTF website:
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

SPECIFIC REQUIREMENTS FOR COVERAGE
The following provisions apply to this Prescription Drug Benefit:

- Prescriptions must be included on Ambetter's *Formulary*. For select *drugs*, *your* doctor must request *authorization*. Requests for these *drugs* are evaluated to determine if the established *approval* criteria are met.
- All *Prescription Drugs* must be obtained from a *network pharmacy*.
- Coverage is provided for *generic*, *brand*, non-preferred brand and *specialty drugs* included on the Ambetter *Formulary*.
- Participating retail and Specialty Pharmacies will dispense prescriptions for up to a 30 day supply.
- Mail Order prescriptions will be dispensed for up to a 90 day supply.
- Some medications may be dispensed in quantities less than those stated above due to prepackaging by the pharmaceutical manufacturer.
- Insulin, diabetic supplies and inhalers may have quantity per *copayment* and/or *coinsurance* payment limitations other than 30 days.
- *You* will be financially liable for the cost of medications obtained after *you* are no longer eligible for *coverage* under this Health Plan.
- Non-*Formulary* (NF) *drugs* require *Formulary* Exception for *coverage*.
- *Prescription Drugs* that are routine patient care provided to *members* participating in clinical trials are covered as required by state and federal law.
- Medications for weight loss that are listed on the *Formulary* may be covered with *prior authorization*.
- Medications for sexual dysfunction that are listed on the *Formulary* may have quantity per *copayment* limitations prescribed in the *Formulary*.

If a *drug* is not on the Drug *Formulary* and is not specifically excluded from *coverage*, *your* doctor can ask for an exception. To request an exception, *your* doctor can submit a *Prior Authorization* request along with a statement supporting the request. Requests for *Prior Authorization* may be submitted by telephone, mail, or facsimile (fax). If *we* approve an exception for a *drug* that is not on the *formulary*, the non-preferred brand tier (Tier 3) *copayment* applies. For a standard exception request, *we* will make a *coverage* determination no later than 72 hours following receipt of the request. If *you* are suffering from a condition that may seriously jeopardize *your* life, health, or ability to regain maximum function, or if *you* are undergoing a current course of treatment using a *drug* that is not on the *Formulary*, then *you*, *your* designee or *your* doctor can request an expedited review. Expedited requests for *Prior Authorization* will be processed within 24 hours after *our* receipt of the request and any additional information requested by *us* that is reasonably necessary to make a determination.

Certain specialty and non-specialty generic medication 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. Note, this provision does not apply to contraceptive and/or preventive pharmacy medications. Further information regarding contraceptive and/or preventive pharmacy medications may be identified under the *Contraceptives and Preventive Pharmacy* section below.

Formulary

Formulary or Preferred Drug List is a listing of covered medications. The *Formulary* consists of following Tiers:

- Tier 0 – Preventative drugs. You will have no cost share for products listed on this tier. This tier includes select oral contraceptives, vitamin D, folic acid for women of child bearing age, over-the counter (OTC) aspirin, and smoking cessation products.
- Tier 1 – Generic drugs. Lowest cost share tier that offers the greatest value compared to other drugs used to treat similar conditions.
- Tier 2 – Preferred branded drugs. Medium cost share.
- Tier 3 – Non-preferred drugs. Highest cost share. This tier also covers non-specialty drugs that are not on the *Formulary* but approval has been granted for coverage. Please see *Prescription Drug Exception Process***.**
- Tier 4 – Specialty drugs. Drugs on this tier are used to treat complex, chronic conditions that may require special handling, storage or clinical management.
- Tier 6 – Cancer drugs. Cost share is set to *your* medical benefit cost share.

In addition to tiers, the *Formulary* also indicates other restrictions that may apply to individual drugs. Summary and explanation of those restrictions can be found in *our* printed *formulary* and includes but is not limited to Prior Authorization, Step Therapy, Quantity Limit, Age Limit, etc. Ambetter's Pharmacy and Therapeutics (P&T) Committee determines placement of drugs on the *formulary*. The P&T Committee consists of practicing physicians and pharmacists and meets at least quarterly.

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.

The P&T Committee conducts quarterly reviews of drugs on the Ambetter *formulary* to determine the appropriateness of tier positioning, the potential for changes based on new drug arrivals or labeling changes, and any pharmaceutical management protocols that may need to be implemented. Additions of medications to the *formulary* and removal of restrictions can happen at any time throughout the year, while negative *formulary* changes are implemented only once per year at the beginning of each benefit year. Negative *formulary* changes include the following: 1) Tier increase; 2) Formulary removal; 3) Addition of *prior authorization* or step therapy; and 4) Addition of quantity limits. *Members* and prescribers affected by negative *formulary* change are notified by letter no less than 60 calendar days prior to implementation of a negative *formulary* change.

Formulary changes made by the P&T Committee are based on the strength of scientific evidence evaluated and are considered against accepted standards of practice including, but not limited to: 1) Assessing peer reviewed medical literature, randomized clinical trials, pharmacoeconomic studies, and outcomes research data; 2) Comparing the safety, efficacy, the frequency of side effects and potential drug interactions among alternative drug products; 3) Assessing the likely impact of a drug product on patient compliance when compared to alternative products; 4) Thoroughly evaluating the benefits, risks and potential outcomes a change could present for patients; and 5) Reviewing and monitoring medication utilization trends and comparing data to recognized and established professional practice standards or protocols to make recommendations for changes in *formulary* positioning.

Voting members of the Committee include practicing community-based practitioners and pharmacists representing various clinical specialties that adequately represent the needs of Ambetter *members*. Outside specialty consultants, independent and free of conflict with respect to Centene Health Plans and pharmaceutical manufacturers, may be recruited, as deemed necessary, to provide input related to their areas of expertise and to provide advice on specialty practice standards.)

PREFERRED SPECIALTY PHARMACIES

As part of *our* Specialty Pharmacy program, certain *drugs* are only available through a Specialty Pharmacy designated by *us*. *We* will contact *you* and *your physician* if a Specialty Pharmacy will now be dispensing a particular *drug* for *you*. *We* will work with *you*, *your physician* and the Specialty Pharmacy to coordinate services such as ordering, delivery and *copayment* collection.

Maintenance Prescription Drug Program

The mail order, or extended day supply program is a convenient and affordable way to buy *your* maintenance *Prescription Drugs*. A maintenance *drug* is one that has been established as an effective, long-term treatment for *your* condition. These *drugs* are used to treat conditions like asthma, heart disease, and high blood pressure.

Through *our* mail order, or extended day supply pharmacy, you can order up to a 90-day supply of *your* maintenance *drug*. Please note prescriptions for 60 day supplies or less are subject to the standard *member cost sharing* amount. Refer to the *Schedule of Benefits* for the mail order *member cost sharing* amount. Pharmacists dispense the *drugs* and then ship them through standard mail at no extra cost to *you*. Contact Member Services for more information on the mail order program.

Cancer Treatment Medications

Patient administered cancer treatment medications, including medications that are orally administered or self-injected, require no higher *copayment*, *deductible* or *coinsurance* amount than cancer treatment medications that are injected or intravenously administered by a health care *provider*. Cancer treatment medications mean *prescription drugs* and biologics that are used to kill, slow or prevent the growth of cancerous cells.

Off-Label Use for Cancer Drugs

We cover off-label use for cancer drugs if such use is supported by nationally recognized guidelines such as the National Comprehensive Cancer Network (NCCN) guidelines or studies evidencing effectiveness and safety.

Medication Synchronization

In accordance with state regulations, upon request, a *member* taking two or more chronic *prescription drugs* may ask a *network pharmacy* to synchronize refill dates so that *drugs* refilled at the same frequency may be refilled concurrently. This will allow the *copayments* to be prorated based on the synchronized days' supply. For questions about this process, please call Member Services at the number listed at the back of *your* ID Card.

CONTRACEPTIVES AND PREVENTIVE PHARMACY
Contraceptive drugs and devices are covered and require a prescription from *your network provider*.

Generic class Food and Drug Administration approved contraceptive methods for all women with reproductive capacity are covered when dispensed by a *network pharmacy*. FDA approved *over-the-counter* contraceptive methods for women are covered when prescribed by a *network provider*. No *deductible*, *copayment* and/ or *coinsurance* shall apply for each prescription or refill of a *generic drug* when dispensed by a *network pharmacy*. If a *generic drug* is not available, no *deductible*, *copayment* and/ or *coinsurance* shall apply for each prescription or refill of a *brand name* contraceptive *drug*. *Deductible*, *copayment* and/ or *coinsurance* will apply to *brand name drugs* that have *generic* equivalents.

No *deductible*, *copayment* and/or *coinsurance* shall apply for each prescription or refill of a *generic drug* when dispensed by a *network pharmacy*. If a *generic drug* is not available, no *deductible*, *copayment* and/or *coinsurance* shall apply for each prescription or refill of a *brand name drug*. *Deductible*, *copayment* and/or *coinsurance* will apply to *brand name drugs* that have *generic* equivalents, unless the prescriber indicates the *brand name drug* is *medically necessary*.

SMOKING CESSATION MEDICATIONS
Smoking cessation medications, including Over the Counter medications that have been included in the *Formulary* by *our* Pharmacy and Therapeutic Committee, are a covered benefit.

For information regarding the smoking cessation program available from Ambetter, contact Member Services at 1-888-926-5057 (TTY: 711).

MEDICAL FOODS
Medical Foods prescribed or ordered under the supervision of a *network physician* or registered nurse practitioner will be covered if *medically necessary* for the therapeutic treatment of an Inherited Metabolic Disorder or to prevent mental or physical impairment arising from an Eosinophilic Gastrointestinal Disorder as defined in this *outpatient prescription drug* Benefit.

Medical foods *coverage* must:
- Be part of the newborn screening program;
- Involve amino acid-based formula carbohydrate or fat metabolism;
- Have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues.

Medical foods *coverage* for Eosinophilic Gastrointestinal Disorder (EGD) m*ust*:
- Have a diagnosis of EGD.

RESIDENTIAL ENTERAL TUBE FEEDING
Medically necessary Enteral Nutrition is a *covered expense* when all of the following apply:
- Prescribed by a *network physician*;
- For use in the home through enteral feeding tubes;
- Feedings exceed 750 kilocalories a day in order to maintain weight and strength commensurate with the *member's* overall health status.

If the requirements above for enteral nutrition are met, supplies, including but not limited to bags, tubing, syringes, irrigation solution, dressings, and tape are also a *covered expense*.

Please note Residential Enteral Tube Feeding is covered under the Medical Supplies benefit for Individuals with an Ambetter *outpatient prescription drug* Benefit. Refer to the Medical Supplies benefit for a description of *covered services* and limitations that apply.

EXCLUSIONS AND LIMITATIONS

Prescription Medications

Outpatient prescription medications except as specifically described in the benefit description titled *Diabetic Supplies, Equipment and Devices*, or as otherwise listed as a *covered service* herein or in the *Schedule of Benefits*. Non- *covered services* include:

- *Drugs* obtained from a *non-network pharmacy;*
- Take home *prescription drugs* and medications from a *hospital* or other *inpatient* or *outpatient facility*;
- Supplies, medications and equipment labeled "Caution - Limited by Federal Law to Investigational Use";
- *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;
- Supplies, medications and equipment deemed *experimental, unproved or investigational* by *us*, except for covered Preventive Medications (as determined to be preventive as recommended by the United States Preventive Services Task Force (USPSTF) A and B recommendations (medications listed at https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/);
- Any non-prescription or *over-the-counter* drugs, devices and supplies that can be purchased without a prescription or *physician* order is not covered, even if the *physician* writes a prescription or order for such *drug*, unless it is an FDA approved *over-the-counter* contraceptive method for women, when prescribed by a *network provider*. Additionally, any *prescription drug* for which there is a therapeutic interchangeable non-prescription or *over-the-counter* drug or combination of non-prescription or *over-the-counter* drugs is not covered, except as prescribed for treatment of diabetes and for smoking cessation;
- Supplies, medications and equipment for other than FDA approved indications;
- Any *drug* consumed at the place where it is dispensed or that is dispensed or administered by the *physician*;
- Supplies, medications and equipment that are not *medically necessary*; as determined by us;
- Medications for infertility;
- Medications purchased before a *member's effective date* of *coverage* or after the *member's* termination date of *coverage*;
- Medications used for *cosmetic* purposes as determined by *us*;
- Vitamins, except those included on Ambetter's *Formulary*;
- Weight reduction programs and related supplies to treat obesity, except as covered under Preventive Care or listed on the *Formulary*;
- Enteral Nutrition when adequate nutrition is possible by dietary adjustment, counseling and/or oral supplements;
- Drugs that require a prescription by their manufacturer, but are otherwise regulated by the FDA as a medical food product and not listed for a covered indication listed in this document;

- For prescription drugs for the treatment of erectile dysfunction or any enhancement of sexual performance unless listed on the *formulary*;
- Foreign prescription medications, except those associated with an emergency medical condition while you are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this section if obtained in the United States; and
- 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.
- For immunization agents, blood, or blood plasma, except when used for preventative care and listed on the *formulary*.
- For a refill dispensed more than 12 months from the date of a physician's order.
- For more than the predetermined managed drug limitations assigned to certain drugs or classification of drugs.
- For any drug that *we* identify as therapeutic duplication through the Drug Utilization Review program.
- 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.
- For medications used for cosmetic purposes.
- For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
- For drugs or dosage amounts determined by Ambetter to be ineffective, unproven or unsafe for the indication for which they have been prescribed, regardless of whether such drugs or dosage amounts have been approved by any governmental regulatory body for that use.
- For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
- For any drug dispensed from a non-lock-in pharmacy while member is in opioid lock-in program.
- For any drug related to *surrogate* pregnancy.
- For any drug used to treat hyperhidrosis.
- For any prescription or over the counter version of vitamin(s) unless otherwise included on the *formulary*.
- For any injectable medication or biological product that is not expected to be self-administered by the *member* at the *member*'s place of residence unless listed on the *Formulary*.

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

Non-Formulary Prescription Drug Exception Process
Standard exception request

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

Expedited exception request

A *member*, a *member's* designee or a *member's* prescribing *physician* may request an expedited review based on exigent circumstances. Exigent circumstances exist when a *member* is suffering from a health condition that may serio*us*ly jeopardize the *enrollee*'s life, health, or ability to regain maximum function or when an *enrollee* is undergoing a current course of treatment *us*ing a non-*formulary drug*. Within 72 hours of the request being received (24 hours for Exigent Circumstances), *we* will provide the *member*, the *member's* designee or the *member's* prescribing *physician* with *our coverage* determination. Should the standard exception request be granted, *we* will provide *coverage* of the non-*formulary drug* for the duration of the exigency.

External exception request review

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

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

PROSTHETIC DEVICES

Internal *prosthetic*/medical appliances are *prosthetics* and appliances that are permanent or temporary internal aids and supports for missing or nonfunctional body parts, including testicular implants following medically appropriate surgical removal of the testicles. Medically appropriate repair, *maintenance* or replacement of a covered appliance is covered.

Covered Services include:

- *Prosthetic devices* including external prosthesis when they are determined to be *medically necessary* and result from an *illness*, *injury*, or surgery causing anatomical functional impairment, or from a *congenital defect*. *Coverage* includes the fitting and purchase of a standard model. Replacement of devices is covered only if determined *medically necessary* or results from a change in the *member's* physical condition or as result of wear and tear.
- Artificial limbs including the initial purchase, and subsequent purchases due to physical growth, for a covered *member* that meets all other screening criteria. *Covered services* must be obtained from a *network provider* in order to be covered. *Coverage* is limited to limbs that are necessary because of an *illness*, *injury* or surgery causing anatomical functional impairment, or from a *congenital defect.*

- The first pair of contacts or corrective lenses and frames following treatment of keratoconus or post- cataract surgery.
- Surgically implanted internal *prostheses* and functional devices that *we* determine to be *medically necessary* to correct a significant functional disorder (e.g. heart pacemakers and hip joints).
- Repair and/or replacement of equipment or parts due to normal wear and tear is covered only when *medically necessary*.
- *Prosthetic* terminal *devices*, including *prosthetics* that substitute for the function of a hand (such as a hook or hand).

Covered Services do not include:
- Repairs and/or replacement of parts or devices worn out due to misuse or abuse.
- Model upgrades.
- Custom breast prosthesis.
- Any costs or expenses for or related to penile implants.
- Any biomechanical devices. Biomechanical devices are any external *prosthetics* operated through or in conjunction with nerve conduction or other electrical impulses.

RECONSTRUCTIVE SURGICAL SERVICES
Covered Services include:
- Surgeries for the correction of disease or *injury* which cause anatomical functional impairment. *Coverage* of surgical procedures will be based upon the reasonable expectation that the condition or disease will be corrected. The determination process will include *our* clinical and medical criteria.
- Reconstructive surgery incidental to medically necessary treatment of medically diagnosed services required for the repair of an accidental injury, congenital defects and birth abnormalities for eligible dependent children.
- Surgical services for breast reconstruction and for post-operative *prostheses* incidental to a *medically necessary* mastectomy. *Coverage* includes reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, *prostheses* and physical complications for all stages of mastectomy, including lymphedemas and external postoperative *prostheses* subject to all of the terms and conditions of the *policy*.

Covered Services do not include:
- Breast reduction which is not *medically necessary*, except following a covered mastectomy or *medically necessary* treatment of gender dysphoria, as specifically provided herein.
- Rhinoplasty and associated surgery, rhytidectomy or rhytidoplasty, breast augmentation (except following a covered mastectomy or *medically necessary* treatment for gender dysphoria as specifically stated herein), blepharoplasty without visual impairment, otoplasty, skin lesions when there is no functional impairment or suspicion of malignancy or located in an area of high friction, or keloids, procedures utilizing an implant which does not alter physiologic function, treatment or surgery for sagging or extra skin, or liposuction.

REHABILITATION SERVICES
Short term Rehabilitation Services and treatments for *acute* conditions when significant improvements can be expected in a predictable period of time are covered. A "predictable period of time" means the length of

time as submitted by the *Primary Care Provider* or referring *physician* or as determined by the rehabilitation *specialist*, and will require *Prior Authorization* by *us*.

Rehabilitative Services include, but are not limited to, the following:

- Physical therapy
- Occupational therapy
- Cardiac rehabilitation
- Pulmonary rehabilitation
- Speech and language services limited to:
    1. Corrections of speech impairment, cognitive or perceptual deficits related to an Accident, *injury*, stroke or surgical procedure or *Autism Spectrum Disorder*.
    2. Therapies for organic swallowing disorders that are related to a medical condition, such as multiple sclerosis and muscular dystrophy.

Rehabilitation therapy for physical impairments in *members* with *Autism Spectrum Disorders* that develops or restores, to the maximum extent practicable, the functioning of an individual, is considered *medically necessary* when criteria for rehabilitation therapy are met.

Please refer to the *Schedule of Benefits* for maximum allowable day limit per *calendar year*.

Except for *medically necessary* services related to behavioral health treatment for *Autism Spectrum Disorders*, the following limitations apply to Rehabilitative Services:

- Routine and/or non- *acute* speech therapy is not covered.
- Services and treatment must be for *acute* impairment of capacity due to *accidental injury* or other medical conditions.
- Services are provided on either an *outpatient*, *inpatient* or home basis as determined by the *Primary Care Provider*, referring *physician* or rehabilitation *specialist* and *us*.
- Rehabilitative services are limited to the maximum allowable number of days per Year, as specified in the *Schedule of Benefits***,** for all services and conditions combined regardless of the number of *injuries* or *illnesses* in one *calendar year*.
- Services provided on the same day, regardless of place of service (*inpatient* rehabilitation, *home health*, or *outpatient facility*, or any combination thereof), will count as one day towards the maximum allowable number of days per Year, as specified in the *Schedule of Benefits*.
- Rehabilitative services provided during an *inpatient hospitals* stay for which rehabilitation is not the primary reason for the *hospital* stay, will not apply to the maximum allowable number of days per Year, as specified in the *Schedule of Benefits*.
- Rehabilitative services related to 1) Developmental delay; 2) Maintaining physical condition; 3) *maintenance* therapy for a Chronic Condition are not *covered services.*
- Continued and repetitive rehabilitative treatment without a clearly defined endpoint is considered *maintenance* and is not covered.
- Functional capacity or work capacity evaluations are not covered.

SECOND OPINION

This plan covers second opinion by a *physician*. A second opinion is an additional evaluation of a *member's* condition by a *physician* to provide their view about the condition and how it should be treated. To request a *referral* to a *specialist* for a second opinion, contact *your Primary Care Provider*. All second opinions must

be provided by a *physician* who has training and expertise in the *illness*, disease or condition associated with the request.

SKILLED NURSING SERVICES
Skilled Nursing Facility Services are covered when determined to be *medically necessary*. *Covered Services* include:

- Admission to a *Skilled Nursing Facility* when appropriate and *medically necessary*.
- Medical care and treatment, including room and board in semi-private accommodations at a *Skilled Nursing Facility* which is a *network provider* for non- *custodial care*.
- *Covered services* shall be of a temporary nature and must be supported by a treatment plan.
- *Covered services* must be approved in advance through *your Primary Care Provider* and *us* with expectations of rehabilitation and increased ability to function within a reasonable and generally predictable period of time.

Covered Services do not include:

- Custodial or domiciliary care.
- Long-term care admissions

SPINAL MANIPULATIONS
Covered Services for spinal manipulations are covered when determined to be *medically necessary*.

TELEMEDICINE SERVICES
We will provide health care services through *telemedicine* under, the following conditions:

- *We* would otherwise provide *coverage* for the service when provided in person by the *health professional*; and
- The *member* is accessing care through an in-network *provider* as defined by their Health Plan.

The following definition applies to the terms mentioned in this provision only. Health Care Services includes, but is not limited to, services provided for the following conditions or in the following settings, including:

- Trauma
- Burn
- Cardiology
- Infectious Diseases
- Mental Health Disorders
- Neurologic Diseases including Strokes
- Dermatology
- Pulmonary Services
- Urology
- Pain Medicine
- Substance Use Disorders

Services not covered include but are not limited to:

Services through *telemedicine* if such services are not otherwise covered when provided in-person. Additionally, the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail without an interaction between the *member* and health care *provider* for the purpose of diagnosis, consultation or treatment is also not covered.

TEMPOROMANDIBULAR SERVICES (TMJ)
Covered Services include *medically necessary* services and treatment for temporomandibular joint syndrome (TMJ) including diagnosis and treatment of TMJ that is recognized by the medical or dental profession as effective and appropriate treatment, including intra-oral splints that stabilize the jaw joint.

Covered Services include services that arise from the following:

- *Accidental injury*
- Physical trauma to the mandible or lower jaw
- Tumor
- *Congenital defects* or developmental defect
- Orthognathic treatment/surgery, dental and orthodontic services and/or appliances that are orthognathic in nature or change the occlusion of the teeth (external or intra-oral) are covered if approved as *medically necessary*

Surgery and Related Services (Often Referred to as "Orthognathic Surgery" or "Maxillary and Mandibular Osteotomy")
For the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw or associated bone joints, except when such procedures are *medically necessary*.

The *copayment* or *coinsurance* for TMJ services in connection with *acute* dislocation of the mandible will vary by place of service pursuant to the *inpatient* and *outpatient services* benefits, respectively. Refer to the *Schedule of Benefits* to determine the applicable *copayment* and/or *coinsurance*.

TRANSPLANT SERVICES - ORGAN & TISSUE
Covered services for transplant service expenses:

Transplants are a covered benefit when a *member* is accepted as a transplant candidate and pre-authorized in accordance with this *contract*. *Prior authorization* must be obtained through the *Center of Excellence*, a *network facility,* or in *our* approved *non-network facility* when there is no network adequacy, before an evaluation for a transplant. *We* may require additional information such as testing and/or treatment before determining medical necessity for the transplant benefit. *Authorization* must be obtained prior to performing any related services to the transplant *surgery*. Transplant services must meet medical criteria as set by Medical Management Policy.

Coverage related to transplant services is available to both the recipient and donor of a covered transplant as follows:

1. If both the donor and recipient have coverage provided by *us* each will have their benefits paid by their own coverage program.
2. If *you* are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this contract will be provided for both *you* and the donor. In this case, payments made for the donor will be charged against *enrollees* benefits.

3. If *you* are the donor for the transplant and no coverage is available to *you* from any other source, the benefits under this contract will be provided for *you*. However, no benefits will be provided for the recipient.
4. If lapse in coverage is due to non-payment of premium, then no services related to transplants will be paid as a covered benefit.

Once medical compatibility has been determined that an *enrollee and donor* are an appropriate candidate for a *medically necessary* transplant, or live donation, *covered service expenses* will be provided for both the transplant recipient and the donor:

1. Pre-transplant evaluation services including medical consultations, office visits, laboratory, and diagnostic testing.
2. Pre-transplant collection or harvesting of the organ from the donor.
3. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
4. Including outpatient covered services related to the transplant surgery, pre- transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection, and other immunosuppressive drug therapy, etc.
5. Pre-transplant stabilization, meaning an *inpatient* stay for *medically necessary* stabilization to prepare for a later transplant, whether or not the transplant occurs.
6. The transplant itself, including the acquisition cost for the organ or bone marrow when authorized through the *Center of Excellence* and services are performed at participating *facility*.
7. Post-transplant follow-up visits and treatments including medical consultations, office visits, laboratory, and diagnostic testing.
8. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.
9. All ancillary costs incurred and medical expenses by the donor; shall be paid under the transplant recipient policy, this includes travel, lodging, food, mileage. Please see transplant travel expense policy for outlined details on reimbursement limitations www. Ambetter.com.

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

Ancillary *Center of Excellence* and *our* Service Benefits:
An *enrollee* may obtain services in connection with a transplant from any *physician*. However, if a transplant is performed in a *Center of Excellence, a network facility,* or in *our* approved *non-network facility* when there is no network adequacy:

1. *We* will pay for the following services when the *enrollee* is required to travel more than 60 miles from the *residence* to the *Center of Excellence,* a *network facility,* or in *our* approved *non-network facility* when there is no network adequacy:
2. *We* will pay for the following services, subject to the maximum identified in the *Schedule of Benefits*:

    a. Transportation for the *enrollee*, any live donor, and the *immediate family* to accompany to and from the *Center of Excellence,* a *network facility,* or in *our* approved *non-network facility* when there is no network adequacy in the United States.

b. When *enrollee* and/or donor is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
c. Maximum reimbursement for mileage is limited to travel to and from the member's home to the transplant facility, and to and from the donor's home to the transplant facility, and will be reimbursed at the current IRS mileage standard for miles driven for medical purposes. Please refer to www.irs.gov for additional information on the current IRS mileage standard.
d. Lodging at or near the *Center of Excellence,* a *network facility,* or in *our* approved *non-network facility* when there is no network adequacy for any live donor and the *immediate family* accompanying the *enrollee* while the *enrollee* is confined in the *Center of Excellence,* a *network facility,* or in *our* approved *non-network facility* when there is no network adequacy in the United States. *We* will reimburse *members* for the proof of costs directly related for transportation, lodging and any of the following approved items listed in the *member* transplant reimbursement guidelines. However, *you* must make the arrangements and provide the necessary paid receipts for reimbursement within 6 months of the date of service in order to be reimbursed.
e. Incurred costs related to a certified/registered service animal for the transplant *enrollee* and/or donor.
f. Please refer to the member resources page for *member* reimbursement transplant travel forms and information at www. Ambetter.com.

Non-Covered Services and Exclusions:

In addition to any other exclusions and limitations described in this *contract*, there are no benefits provided or paid under these Transplant Service Expense Benefits for the following:

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of a human organ or tissue, not obtained through the *Center of Excellence,* a *network facility,* or in *our* approved *non-network facility* when there is no network adequacy.
4. To keep a donor alive for the transplant operation, except when authorized through the *Center of Excellence,* a *network facility*, or in *our* approved *non-network facility* when there is no network adequacy.
5. For a live donor to receive an organ transplant to replace the donated organ.
6. Related to transplants unauthorized though the *Center of Excellence,* a *network facility,* or in *our* approved *non-network facility* when there is no network adequacy and is not included under this provision as a transplant.
7. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (USFDA) regulation, regardless of whether the trial is subject to USFDA oversight.
8. The acquisition cost for the organ or bone marrow, when provided at an un*authorized facility* or not obtained through the *Center of Excellence,* a *network facility,* or in *our* approved *non-network facility* when there is no network adequacy.
9. For any transplant services and/or travel related expenses for *enrollee* and donor, when preformed outside of the United States.

10. The following ancillary items listed below, will not be subject to member reimbursement under this policy:

    a. Alcohol/tobacco
    b. Car Rental (unless pre-approved by Case Management)
    c. Vehicle Maintenance for motorized and hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, ect.)
    d. Parking, such as but not limited to hotel, valet or any offsite parking other than hospital.
    e. Storage rental units, temporary housing incurring rent/mortgage payments.
    f. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, ect.
    g. Speeding tickets
    h. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
    i. For any services related to pet care, boarding, lodging, food, and/or travel expenses; other than those related to certified/registered service animal(s).
    j. Expenses for persons other than the patient and his/her covered companion
    k. Expenses for lodging when member is staying with a relative
    l. Any expense not supported by a receipt
    m. Upgrades to first class travel (air, bus, and train)
    n. Personal care items (e.g., shampoo, deodorant, clothes)
    o. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA precheck, and early check-in boarding fees, extra baggage fees.
    p. Souvenirs (e.g., t-shirts, sweatshirts, toys)
    q. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type
    r. Any fuel costs / charging station fees for electric cars, not related to travel to and from the *Center of Excellence* or *our* approved *facility* when there is no network adequacy.

Organ Transplant Medication Notification

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

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

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

URGENT CARE SERVICES
We encourage *members* to contact their *Primary Care Provider* before seeking *urgent care* services.

Urgent Care is defined as those services, which are provided for the relief of *acute* pain, initial treatment of *acute* infection, or a medical condition that requires medical attention, but a brief time lapse before care is obtained does not endanger life or permanent health. Examples of *urgent care* Services would include minor sprains, fractures, pain, and heat exhaustion. An individual patient's urgent condition may become *emergent* upon evaluation by a *network provider*.

Covered Services for *urgent care*:

- Include treatment for unforeseen medical conditions (initial visit only).
- Are determined by the Plan in accordance with generally accepted medical standards to have been necessary to treat a condition requiring prompt medical attention.
- Require the *member* to provide full details, including medical records of *urgent care* services rendered by a *non-network provider*, if requested by this Health Plan. Costs associated with *urgent care* services will be reimbursed only after *we* receive and review the *urgent care* medical records and determine that such services were *medically necessary*. Services which have been *authorized* will not be retrospectively denied during the review of expenses incurred.

Covered Services do not include:

- Continuing, routine or follow-up care in an *Urgent Care Facility*, unless *authorized* by *your Primary Care Provider*.

Services performed at an *Urgent Care* Facility (including but not limited to: x-rays and lab testing) may be subjected to additional *member cost sharing* above the *urgent care cost sharing*.

***Routine Care* provided by an *Urgent Care Provider* is not covered unless *authorized* by *your Primary Care Provider*.** The *member* will be financially responsible for any *urgent care provider* expenses for non-*urgent care*. *Routine care* includes, but is not limited to, conditions such as colds, flu, sore throats, superficial injuries, minor infections, follow-up care and preventive care.

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

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

a. Progressive lenses (standard or premium);
b. Intermediate vision lenses;
c. Blended segment lenses;
d. Hi-Index lenses;
e. Plastic photosensitive lenses;
f. Photochromic glass lenses;
g. Glass-grey #3 prescription sunglass lenses;
h. Fashion and gradient tinting;
i. Ultraviolet protective coating;
j. Polarized lenses;
k. Scratch resistant coating;
l. Anti-reflective coating (standard, premium or ultra);
m. Oversized lenses;
n. Polycarbonate lenses.

5. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Please refer to *your Schedule of Benefits* for a detailed list of *member cost sharing*, annual maximum and appropriate service limitations. To see which vision *providers* are part of the *network,* please visit http://ambetter.azcompletehealth.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.*

MEDICAL VISION SERVICES

Covered services include:

- Vision screenings to diagnose and treat a suspected disease or *injury* of the eye.
- Vision screenings to determine the presence of refractive error.
- *Members* who have been diagnosed with diabetes may self-refer once each Year to an eye care *specialist* within their *network*, or an Ambetter contracted eye care *specialist* if none is available within the Ambetter *network*, for the purpose of receiving an eye exam for the detection of eye disease. Continued, or follow-up care from the eye care *specialist* will require a *referral* through *your Primary Care Provider*.

Vision Services under the medical portion of *your health plan* do not include:

- *Referrals* to a *specialist* for evaluation and diagnosis of refractive error, including presbyopia, for *members* over the age of 19 years.
- Eye examinations required by an employer or as a condition of employment.
- Radial keratotomy, LASIK and other refractive eye surgery.
- Services or materials provided as a result of any workers' compensation law, or required by any governmental agency. Orthoptics, vision training or subnormal vision aids.

SOCIAL DETERMINANTS OF HEALTH SUPPLEMENTAL BENEFITS

Social determinants of health supplemental benefits and services may be offered to *enrollees* to remove barriers to accessing health services and improve overall health outcomes. These are benefits and services

that *we* may make available in connection with this *contract*. The benefits and services provided may include transportation to health services, assistance with childcare, access to healthy meals, and other relevant services based on need. The benefits are available as long as *coverage* remains active, unless changed by *us*. Upon termination of *coverage*, the benefits are no longer available. All *enrollees* are automatically eligible for the benefits upon obtaining *coverage*. The services are optional, and the benefits are made available at no additional cost to the *enrollees*. The benefits and services available at any given time are made part of this *contract* by this reference and are subject to change by *us* through an update to information available on *our* website or by contacting *us*.

Social determinants of health benefits and services may be offered to *enrollees* through the "My Health Pays" wellness program and through local health plan websites. *Enrollees* may receive notifications about available benefits and services through emails from local health plans and through the "My Health Pays" notification system. To inquire about these benefits and services or other benefits available, *you* may visit *our* website at https://ambetter.azcompletehealth.com/ or by contacting Member Services at 1-888-926-5057 (TTY: 711).

WELLNESS AND OTHER PROGRAM BENEFITS

Benefits may be available to enrollees for participating in certain programs that *we* may make available in connection with this *contract*. Such programs may include wellness programs, disease or care management programs, and other programs as found under the Health Management Programs Offered provision. These programs may include a reward or an incentive, which you may earn by completing different activities.

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

You may obtain information regarding the particular programs available at any given time by visiting *our* website at https://ambetter.azcompletehealth.com/ or by contacting Customer Service by telephone at 1-888-926-5057 (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 *enrollees* are automatically eligible for program benefits upon obtaining *coverage*. The programs are optional, and the benefits are made available at no additional cost to the *enrollees*. The programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change by *us* through updates available on *our* website or by contacting *us*.

X-RAY AND LABORATORY SERVICES

Covered Services include:

- Diagnostic x-rays
- Electrocardiograms
- Laboratory tests
- Portable x-rays
- X-ray therapy
- Fluoroscopy
- Therapeutic radiology services
- Mammography screenings

***Copayments* and *coinsurance* may be different depending on whether the services are received at a *physician's* office, or a *hospital*, *Outpatient* Surgery Facility or *Ambulatory Surgical Facility*.**

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

In addition to the Limitations and Exclusions described in the section titled *Description of Benefits* the following services are not covered or are limited in benefit application unless expressly stated herein:

Abortions
Elective abortions are not covered under this Health Plan. Abortions which are determined to be *medically necessary* to save the life of the *member*, or due to rape, incest, life-endangerment, or necessary to avert substantial and irreversible impairment of a major bodily function of the *member* having the abortion are covered.

Alternative Therapies
Acupuncture, acupressure, hypnotherapy, biofeedback (for reasons other than pain management, and for pain management related to Mental Health and Substance Use) behavior training, educational, recreational, art, dance, sex, sleep or music therapy, and other forms of holistic treatment or alternative therapies, unless otherwise specifically stated as a covered benefit herein.

Applied Behavioral Health Therapy (ABA)
ABA is only covered for the treatment of *Autism Spectrum Disorder*. The following services are not covered:

- Sensory Integration,
- LOVAAS Therapy and
- Music Therapy.

Bariatric Surgery
We provide*s* benefits for *medically necessary* and not *experimental, unproved or investigational*. These *covered services* must be *authorized* by *us* in accordance with *our* evidence based criteria for this intervention contained in *our* National Medical Policy on Bariatric Surgery which can be found at https://ambetter.azcompletehealth.com/ under the medical policies link. Benefits are not payable for expenses excluded in the EOC or for the following:

- Jejunoileal bypass (jejuno-colic bypass)
- Loop Gastric Bypass (i.e., "Mini-Gastric Bypass")
- Open sleeve gastrectomy
- Gastric balloon
- Gastric wrapping
- Gastric Imbrication
- Gastric pacing
- Fobi pouch

Benefits or Services (Non-Covered)
Services, supplies, treatments or accommodations which:

- Are not *medically necessary* except as specifically described herein;
- Are not specifically listed as a covered service herein, whether or not such services are *medically necessary*;
- Are incident or related to a non-covered service;
- Are not considered generally accepted health care practices;
- Are considered *cosmetic* as determined by *us*, unless specifically listed as a *coverage* herein;

- Are provided prior to the *effective date* of *coverage* hereunder, or after the termination date of *coverage* hereunder;
- Are provided under *Medicare* or any other government program except *Medicaid*;
- The person is not required to pay, or for which no charge is made.
- Any service or supply that would be provided without cost to the *member* in the absence of insurance covering the charge.
- 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.
- Any services not identified and included as *covered services* under the *contract*. You will be fully responsible for payment for any services that are not *covered services*.
- Any services where other coverage is primary to Ambetter must be first paid by the primary payor prior to consideration for *coverage* under Ambetter.

Blood Products
Collection and/or storage of blood products to include stem cells for any unscheduled medical procedure, or non-covered medical procedures. Salvage and storage of umbilical cord and/or after birth are not covered.

Braces
- *Over-the-counter* braces;
- Prophylactic braces;
- Braces used primarily for sports activities.

Breast Implants, Prostheses
Breast implants, including replacement, except when *medically necessary*, and related to a *medically necessary* mastectomy. Removal of breast implants, except when *medically necessary*.

Cannabis or Marijuana
For any medicinal or recreational use of cannabis or marijuana.

Chiropractic Care
- Any services provided by a *non- network chiropractor* regardless of whether the services were obtained within or outside of the Health Plan's Service Area;
- Any services, including consultations (except for the initial evaluation visit), that are not *authorized* by the designated Chiropractic *provider* as shown in the *Schedule of Benefits*;
- Any treatments or services, including x-rays, determined to not be related to neuromusculoskeletal disorders*;*
- Services which are not provided in a *network chiropractor's* office;
- Services or expenses which exceed the *member's* maximum allowable benefit. Services which exceed the *member's* maximum allowable benefit will be the *member's* financial responsibility;
- Expenses incurred for any services provided before *coverage* begins or after *coverage* ends according to the terms of this *policy*;
- Preventive care, educational programs, non-medical self-care, self-help training, or any related diagnostic testing, except that which occurs during the normal course of covered chiropractic treatment;
- Prescription medications. Vitamins, nutritional supplements or related products, even if they are prescribed or recommended by a *network chiropractor*;

- Services provided on an *inpatient* basis;
- Rental or purchase of Durable Medical Equipment, air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices, appliances or equipment as ordered by *network chiropractor* even if their use or installation is for the purpose of providing therapy or easy access;
- Expenses resulting from a missed appointment which the *member* failed to cancel;
- Treatment primarily for purposes of obesity or weight control;
- Vocational rehabilitation and long-term rehabilitation;
- Hypnotherapy, acupuncture, behavior training, sleep therapy, massage or biofeedback;
- Radiological procedures performed on equipment not certified, registered or licensed by the State of Arizona, or the appropriate licensing agency, and/or radiological procedures that, when reviewed by the designated Chiropractic *provider* as shown in the *Schedule of Benefits*, are determined to be of such poor quality that they cannot safely be utilized in diagnosis or treatment;
- Services, lab tests, x-rays and other treatments not documented as clinically necessary as appropriate or classified as *experimental, unproved or investigational* and/or as being in the research stage;
- Services and/or treatments that are not documented as *medically necessary* services;
- All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids;
- Adjunctive therapy not associated with spinal, muscle or joint manipulation;
- Manipulation under anesthesia.

Circumcision
Non- *medically necessary* circumcisions after the *newborn period*, including cases of premature birth.

Communication and Accessibility Services
Provider expenses for interpretation, translation, accessibility or special accommodations.

Complications of Non-Covered Expenses
Complications of an ineligible or excluded condition, procedure or service (non- *covered expenses*), including services received without *authorization*.

Cosmetic Surgery or Reconstructive Surgery
Cosmetic or Reconstructive surgery, which in the opinion of *us* is, performed to alter an abnormal or normal structure solely to render it more esthetically pleasing where no significant anatomical functional impairment exists. The following are examples of non- *covered services*:

- Rhinoplasty and associated surgery
- Rhytidectomy or rhytidoplasty
- Breast augmentation/implantation
- Blepharoplasty without visual impairment
- Breast reduction which is not *medically necessary*, as determined by *us*
- Otoplasty
- Skin lesions without functional impairment, suspicion of malignancy or located in area of high friction
- Keloids
- Procedures utilizing an implant which does not alter physiologic function

- Treatment or surgery for sagging or extra skin
- Liposuction
- Non- *medically necessary* removal or replacement of breast implants, as determined by *us*

Cosmetic or reconstructive surgery performed, in *our* opinion, to correct injuries that are the result of *accidental injury* is a covered service. In addition, this exclusion does not apply to breast reconstruction incidental to a covered mastectomy for either the breast on which the mastectomy has been performed or for surgery and reconstruction of the other breast to produce a symmetrical appearance. Reconstructive surgery incidental to birth abnormalities of a covered *dependent* is limited to the *medically necessary* care and treatment of medically diagnosed *congenital defect* and birth abnormalities of a newborn, adopted child or child placed for adoption. Surgery will be covered past the *newborn period* if *medically necessary* and medical criteria are met.

Counseling Services
Unless otherwise specifically stated as a covered benefit herein.

- Counseling for conditions that the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) identifies as relational problems (e.g. couples counseling, family counseling for relation problems) Note, DSM is the handbook used by health care professionals in the United States as the authoritative guide to the diagnosis of mental disorders. DSM contains descriptions, symptoms, and other criteria for diagnosing mental disorders. The DSM provides a common language for clinicians to communicate about their patients and establishes consistent and reliable diagnoses that are related to mental disorders
- Counseling for conditions that the DSM identifies as additional conditions that may be a focus of clinical attention (e.g. educational, social, occupational, religious, or other maladjustments)
- Sensitivity or stress-management training and self-help training

Court or Police Ordered Services
Examinations, reports or appearances in connection with legal proceedings, including child custody, competency issues, parole and/or probation and other court ordered related issues. Services, supplies or accommodations pursuant to a court or police order, whether or not *injury* or sickness is involved, unless otherwise noted within the *policy*.

Custodial Care
Any service, supply, care or treatment that *we* determine to be incurred for rest, domiciliary, convalescent or *custodial care*. Examples of non- *covered services* include:

- Any assistance with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medications;
- Any care that can be performed safely and effectively by a person who does not require a license or certification or the presence of a supervisory nurse;
- Non-covered *custodial care* Services no matter who provides, prescribes, recommends or performs those services;
- Services of a person who resides in the *member's* home, or a person who qualifies as a *family member*;
- The fact that certain *covered services* are provided while the *member* is receiving *custodial care* does not require *us* to cover *custodial care*.

Dental Services
The *medical* portion of *your health plan* covers only those dental services specifically stated in the section titled *Description of Benefits*. All other dental services are excluded.

Devices
Bionic and hydraulic devices, except when otherwise specifically described herein.

Dietary Food or Nutritional Supplements
Non- *covered services* include the following:

- Dietary food, nutritional supplements, special formulas, and special diets provided on an *outpatient*, ambulatory or home setting;
- Food supplements and formulas, including enteral nutrition formula, provided in an *outpatient*, ambulatory or home setting except as otherwise stated herein or in the *Schedule of Benefits*;
- Nutritional supplementation ordered primarily to boost protein-caloric intake or the mainstay of a daily nutritional plan in the absence of other pathology, except as otherwise stated herein or in the *Schedule of Benefits*. This includes those nutritional supplements given between meals to increase daily protein and caloric intake;
- Services of nutritionists and dietitians, except as incidentally provided in connection with other *covered services*.

Disability Certifications
Disability Certifications if not required by *us*.

Durable Medical Equipment
Durable Medical Equipment that fails to meet the criteria as established by *us*. Examples of Non- *covered services* include, but are not limited to the following:

- Exercise equipment, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses, or waterbeds, escalators or elevators, ramps, automobile modifications, safety bars, saunas, swimming pools, Jacuzzi or whirlpools, and hygienic equipment;
- Equipment for a patient in an institution that is ordinarily provided by an institution, such as wheelchairs, hospital beds and oxygen tents, unless these items have been *authorized* by *us*;
- More than one *DME* device designed to provide essentially the same function;

- Deluxe, electric, model upgrades, *specialized or custom durable medical equipment*, *prosthetics* or *orthotics* or other non-standard equipment;
- Repair or replacement of deluxe, electric, *specialized or custom durable medical equipment*, model upgrades, and portable equipment for travel;
- Transcutaneous Electrical Nerve Stimulation (TENS) units;
- Scooters and other power operated vehicles;
- Warning devices, stethoscopes, blood pressure cuffs, or other types of apparatus used for diagnosis or monitoring,
- Model upgrades and duplicates, except as specifically listed as being covered herein;
- Repair, replacement or routine *maintenance* of equipment or parts due to misuse or abuse;
- Over-the counter braces and other *DME* devices, except as specifically listed as being covered herein;
- Prophylactic braces and other *DME* devices, except as specifically listed as being covered herein;
- Braces used primarily for sports activities;
- ThAIRapy® vests, except when *our* medical criteria is met;
- Communication devices (speech generating devices) and/or training to *us*e such devices; and
- Pulse oximeters.

Emergency Services
Use of *emergency facilities* for non-*emergency* purposes. *Routine Care*, follow-up care or continuing care provided in an Emergency Facility, unless such services were *authorized* by the *Primary Care Provider* or *us*.

Exercise Programs
Exercise programs, yoga, hiking, rock climbing and any other types of sports activity, equipment, clothing or devices.

Ex-Member (Services for)
Benefits and services provided to an ex- *member* after termination of the ex- *member.*

Experimental, Investigational Procedures, Devices, Equipment and Medications
Experimental, unproved or investigational medical, surgical or other *experimental* health care procedures, services, supplies, medications, devices, equipment or substances. *Experimental, unproved or investigational* procedures, services or supplies are those which, in *our* judgment:

- Are in a testing stage or in field trials on animals or humans;
- Do not have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed;
- Are not in accordance with generally accepted standards of medical practice;
- Have not yet been shown to be consistently effective for the diagnosis or treatment of the *member's* condition;
- Are medications or substances being used for other than FDA approved indications; and/or
- Are medications labeled "Caution, Limited by Federal Law to Investigational Use.".

This exclusion does not apply to *coverage* for routine patient costs provided to *members* participating in approved Clinical Trials as required by state and federal law and defined in this *Policy*.

Family Member (Services Provided by) and Member Self-Treatment
Professional services, supplies or *provider referrals* received from or rendered by a non-Ambetter contracted immediate *family member* (*spouse*, domestic partner, child, parent, grandparent or sibling related by blood, marriage or adoption) or prescribed or ordered by a non-Ambetter contracted immediate *family member* of the *member*; *Member* self-treatment including, but not limited to self-prescribed medications and medical self-ordered services.

Foot Orthotics
See exclusion titled *orthotics*.

Fraudulent Services
Services or supplies that are obtained by a *member* or non-*member* by, through or otherwise due to fraud.

Gastric Stapling/Gastroplasty
Open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, and open adjustable gastric banding.

Genetic Testing, Amniocentesis
Services or supplies in connection with genetic testing, except those which are *medically necessary* or included in the preventive services section, as determined by *us*. Genetic testing, amniocentesis, ultrasound, or any other procedure required solely for the purpose of determining the sex of a fetus.

Governmental Hospital Services
Services provided by any governmental unit except as required by federal law for treatment of veterans in Veterans Administration or armed forces Facilities for non-service related medical conditions. Care for conditions that federal, state, or local law requires treatment in a public *facility.*

Habilitative Services
Habilitative services when medical documentation does not support the *medical necessity* because of the *member's* inability to progress toward the treatment plan goals or when a *member* has already met the treatment plan goals.

Speech therapy is not covered for occupational or recreational voice strain that could be needed by professional or amateur voice users, including, but not limited to, public speakers, singers, cheerleaders. Examples of health care services that are not habilitative include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, *custodial care*, or education services of any kind, including, but not limited to, vocational training.

Hair Analysis, Treatment and Replacement
Testing using a patient's hair except to detect lead or arsenic poisoning; hair growth creams and medications; implants; scalp reductions.

Heavy Metal Screening and Mineral Studies
Heavy metal screenings and mineral studies. Screening for lead poisoning is covered when directed through the *Primary Care Provider*.

Home Maternity Services
Services or supplies for maternity deliveries at home.

Household and Automobile Equipment and Fixtures
Purchase or rental of household equipment or fixtures having customary purposes that are not medical. Examples of Non- *covered services* include: exercise equipment, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses or waterbeds, escalators or elevators, ramps, automobile modifications, safety bars, saunas, swimming pools, Jacuzzi or whirlpools, hygienic equipment or other household fixtures.

Immunizations
Immunizations that are not *medically necessary* or medically indicated.

Impotence (Treatment of)
All services, procedures, devices associated with impotence or erectile dysfunction regardless of associated medical, emotional or psychological conditions, causes or origins unless otherwise specifically stated herein.

Ineligible Status
Services or supplies provided before the *effective date* of *coverage* are not covered. Services or supplies provided after midnight on the *effective date* of cancellation of *coverage* are not covered.

A service is considered provided on the day it is performed. A supply is considered provided on the day it is dispensed.

Infertility Services
Services associated with infertility are limited to diagnostic service rendered for infertility evaluation. The following services and treatments are not covered:

- Artificial insemination services
- Reversal of voluntary sterilization procedures
- In vitro fertilization
- Embryo or ovum transfer
- Zygote transfers
- Gamete transfers
- GIFT procedure
- Cost of donor sperm or sperm banking
- Foams and condoms
- Medications used to treat infertility
- Services, procedures, devices and medications associated with impotence and/or erectile dysfunction unless otherwise specifically stated herein

Institutional Requirements
Expenses for services provided solely to satisfy institutional requirements.

Late Fees, Collection Expenses, Court Costs, Attorney Fees
Any late fees or collection expenses that a *member* incurs incidental to the payment of services received from *providers*, except as may be required by state or federal law. Court costs and attorney fees. Costs due to failure of the *member* to disclose insurance information at the time of treatment.

License (Not Within the Scope of)
Services beyond the scope of a *provider's* license

Lost Wages and Compensation for Time
Lost wages for any reason. Compensation for time spent seeking services or *coverage* for services.

Medical Supplies
Consumable or disposable medical supplies, except as specifically provided herein. Examples of non-*covered services* include bandages, gauze, alcohol swabs and dressings, foot coverings, leotards, elastic knee and elbow Supports not provided in the *Primary Care Provider's* office, except as required by state or Federal law. Medical supplies necessary to operate a non-covered *prosthetic device* or item of *DME*.

Mental Health
Covered Services do not include the following:

- Services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
- Pre-marital counseling;
- 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*;
- Testing of aptitude, ability, intelligence or interest;
- Evaluation for the purpose of maintaining employment;
- Expenses incurred for missed appointments or appointments not canceled 24 hours in advance;
- Wilderness programs and/or therapeutic boarding schools that are not licensed as *Residential Treatment Centers*.

Missed Appointments, Telephone and Other Expenses
The following are not covered:

- Expenses made to *member* by a *provider* for not keeping or the late cancellation of appointments.
- Charges by *members* or *providers* for telephone consultations, except for Services provided through *telemedicine* if such services are otherwise covered when provided in person, and clerical services for completion of special reports or forms of any type, including but not limited to Disability certifications are not covered.
- Charges by *members* or *providers* for copies of medical records supplied by a health care *provider* to *member*.

Telemedicine services are covered as shown under the "Description of Benefits" section in this EOC.

Non-Licensed Providers
Treatment or services rendered by non-licensed health care *providers* and treatment or services outside the scope of a license of a licensed health care *provider* or services for which the *provider* of services is not required to be licensed. This includes treatment or services from a non-licensed *provider* under the super-

vision of a licensed *physician*, except for services related to behavioral health treatment for *autism spectrum disorder*.

Non-Medically Necessary Services
Services, supplies, treatments or accommodations which are not *medically necessary* except as specifically described herein.

Non-Participating Pharmacy
Benefits and services from *non- network pharmacies* (any Pharmacy that has not contracted with Ambetter from Arizona Complete Health to provide prescription medications to *members* covered under this *policy*) are not covered.

Non-Participating Provider (Services Rendered by)
Benefits and services from *non-network providers*, except in the case of a medical *emergency* or under an approved *network* exception.

Nutritionists
Services of nutritionists and dietitians, except as incidentally provided in connection with other *covered services*.

Obesity
Treatment or surgery for obesity, weight reduction or weight control, except when provided for morbid obesity or as a Preventive Care Services.

Orthotics
- Repair, *maintenance* and repairs due to misuse and/or abuse.
- *Over-the-counter* items, except as specifically listed as being covered herein.
- Prophylactic braces.
- Braces used primarily for sports activities.

Out-of-Service Area Services
Unauthorized services received outside of Ambetter's Service Area, except for *emergency services* as defined in this *policy*. Examples of non- *covered services* include the following:
- Non-*emergent* services or treatments which could have been provided by a *network provider* within the Service Area;
- Non-*emergent* services which were furnished after the *member's* condition would have permitted the *member* to return to the Service Area for continued care;
- Non-*emergent* services connected with conditions resulting during travel which had been advised against because of health reasons such as impending surgery and/or delivery. This does not apply to *emergency services* as defined in this *policy*; and
- Treatment in progress by a *network provider*.

Over-the-Counter Items and Medications
Over-the-counter items and medications, except as specifically listed as a covered benefit herein. Exceptions covered herein include covered Preventive Medications, and medications as indicated under the provisions titled Diabetic Supplies, Equipment and Devices. For purposes of this *policy*, *over-the-counter* is defined as

any item, supply or medication which can be purchased or obtained from a vendor or without a prescription.

Oxygen
Oxygen when services are outside of the Service Area and non-*emergent* or Urgent, or when used for convenience when traveling within or outside of the Service Area.

Paternity Testing
Diagnostic testing to establish paternity of a child.

Penile Implants
Any costs or expenses for or related to penile implants.

Personal Comfort Items
Personal comfort or convenience items, including services such as guest meals and accommodations, telephone expenses, non-*Qualified Travel Expenditures*, take-home supplies, barber or beauty services, radio, television and private rooms unless the private room is *medically necessary*.

Physical and Psychiatric Exams
Physical health examinations in connection with the following:

- Obtaining or maintaining employment,
- Obtaining or maintaining insurance qualification.

Psychiatric or psychological examinations, testing and/or other services in connection with:

- Obtaining or maintaining employment,
- Obtaining or maintaining insurance relating to employment or insurance,
- Obtaining or maintaining any type of license,
- Medical research,
- Competency issues.

Physical Conditioning
Health conditioning programs and other types of physical fitness training. Exercise equipment, clothing, performance enhancing drugs, nutritional supplements and other regimes.

Prescription Medications
Refer to the *outpatient prescription drug* benefit for the restrictions and limitations that apply.

Private Duty Nursing
Private Duty Nursing and private rooms except when determined to be *medically necessary* as determined by *us*. *Private Duty Nursing* does not include non-skilled care, *custodial care*, or respite care.

Public or Private School
Charges by any public or private school or halfway house, or by their employees.

Radial Keratotomy, Lasik
Radial Keratotomy, LASIK surgery and other refractive eye surgery.

Residential Treatment Center
Residential treatment that is not *medically necessary* is excluded. Admissions that are not considered medically appropriate and are not covered include admissions for wilderness center training; for *custodial care*; for a situational or environmental change; or as an alternative to placement in a foster home or halfway house.

Reversal of voluntary sterilization procedures
Expenses for services to reverse voluntary sterilization.

Routine Foot Care
Routine foot care. Examples of non- *covered services* include trimming of corns, calluses and nails, and treatment of flat feet.

Shipping, Handling, Interest Expenses
All shipping, delivery, handling or postage expenses except as incidentally provided without a separate charge, in connection with *covered services* or supplies. Interest or finance charges except as specifically required by law.

Skin Titration Testing
Skin titration (wrinkle method), cytotoxicity testing (Bryans Test), RAST testing, MAST testing, urine auto-injection, provocative and neutralization testing for allergies.

Speech and Language Services
Speech therapy services, *maintenance* and/or non- *acute* therapies, or therapies where a significant and measurable improvement of condition cannot be expected in a reasonable and generally predictable period of time as determined by *us* in consultation with the treating *provider*. Any combination of therapies (including speech and language therapies) that exceed the maximum allowable benefits as described in the *Schedule of Benefits.* Communication devices (speech generating devices). Rehabilitative services relating to developmental delay, provided for the purpose of maintaining physical condition, or *maintenance* therapy for a Chronic Condition are not covered. However, Rehabilitation and habilitation therapy for physical impairments in *members* with *autism spectrum disorders* that develops or restores, to the maximum extent practicable, the functioning of an individual, is considered *medically necessary* when criteria for rehabilitation and habilitation therapy are met.

Substance Use Services
Covered Services do not include:

- *Referral* for non- *medically necessary* services such as vocational programs or employment counseling.
- Expenses related to a stay at a sober living *facility*. Sober living *facilities* are *custodial care* institutions, which are not a covered benefit.

Surrogacy Arrangement
Health care services, including supplies and medication, to a *surrogate*, including a *member* and/or *family member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a *member* and/or *family 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:

- Prenatal care;
- Intrapartum care (or care provided during delivery and childbirth);
- Postpartum care (or care for the *surrogate* following childbirth);
- Mental Health Services related to the *surrogacy arrangement*;
- Expenses relating to donor semen, including collection and preparation for implantation;
- Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
- Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
- Preimplantation genetic diagnosis relating to a *surrogacy arrangement*;
- Any complications of the child or *surrogate* resulting from the pregnancy; or
- 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.

Temporomandibular Joint Disorder (Treatment of)
Covered Services under the *medical* portion of *your health plan* do not include:

- Dental prosthesis or any treatment on or to the teeth, gums, or jaws and other services customarily provided by a dentist or dental *specialist*;
- Treatment of pain or infection due to a dental cause, surgical correction of malocclusion prognathic surgery, orthodontia treatment, including *hospital* and related costs resulting from these services when determined to relate to malocclusion; and
- Treatment of obstructive sleep apnea.

Thermography
Thermography or thermograms related expenses.

Transplant Services
Covered Services for transplants do not include:

- Services, supplies and medications provided to a donor of organs and/or tissue, for transplants where the recipient is not a *member* covered under this health Plan.
- Transplants that are considered *experimental, unproved or investigational*.
- If *you* are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this contract will be provided for both *you* and the donor. In this case, payments made for the donor will be charged against *enrollees* benefits.

This exclusion does not apply to *coverage* for routine patient costs provided to *members* participating in approved Clinical Trials as required by state and federal law and defined in this *policy*.

Transportation Services
Transportation of a *member* to or from any location for treatment or consultation, except for ambulance services associated with a *medically necessary emergency* condition and travel services associated with organ transplant benefits. Travel and lodging are not covered if the *member* is a donor.

Travel Expenses
Travel and room and board, even if prescribed by a *physician* for the purpose of obtaining *covered services*. This does not apply to *Qualified Travel Expenditures*.

Urgent Care Services
Use of *Urgent Care Facilities* for non- *urgent care* purposes. *Routine Care*, follow-up or continuing care provided in an *Urgent Care Facility*.

Vision Services
Vision services are covered as specified in the Vision Services section under the Description of Benefits of this *policy* and the *Schedule of Benefits.*

Pediatric Vision Services and supplies when *medically necessary* are covered for children up to the last day of the month they turns age 19, as described in the *Schedule of Benefits* under Pediatric Vision Services.

The following Adult Vision Services are not covered:

- Eyeglasses and contact lenses, and the vision examination for prescribing and fitting of same, except as specifically listed as a covered benefit herein.
- Eye examinations required by an employer as a condition of employment.
- Services or materials provided as a result of any workers' compensation law, or required by any government agency.
- Radial keratotomy and other refractive eye surgery.
- Orthoptics, vision training, or subnormal vision aids.

If *you* have elected additional Adult Vision Benefits, please refer to the Vision Benefit Rider for a description of services and the limitations that apply.

Vitamin B-12 Injections
Vitamin B-12 injections are not covered except for the treatment of pernicious anemia when oral vitamin B cannot be absorbed.

Vocational Programs/Employment Counseling
Vocational programs and counseling for employment, including counseling during mental or substance use rehabilitation.

Work-Related Injuries
Expenses in connection with a work-related injury or sickness for which coverage is provided under any state or federal Worker's Compensation, employer's liability or occupational disease law.

DEPENDENT MEMBER COVERAGE & ONGOING ELIGIBILITY

Eligibility Requirements
Coverage under this *health plan* is available to individuals who satisfy the eligibility requirements as described in this section.

Subscriber Eligibility
Eligible *members* may apply for *coverage* under this Health Plan, provided that the individual:

- Resides within Ambetter from Arizona Complete Health's Service Area when applying for membership under this *policy*; or
- Satisfies either the Discretionary or Automatic Eligibility Requirements as described herein.

If the *eligible child* enrolled under this Agreement is under the age of 21 and has been enrolled by an eligible *member*, the eligible *member* signing for *coverage* on behalf of the Child agrees to be responsible for the administrative and premium requirements of the *coverage*. *Dependents* of the *eligible child* cannot be enrolled and cannot be *members* under this Agreement. No benefits shall be payable on behalf so such *dependents*.

Dependent Eligibility
Eligible *dependents* of the *member* may apply for *dependent coverage* under this *policy*, provided that the *family member*:

1. Meets the *dependent* eligibility requirements as defined below; and
2. Satisfies either the Discretionary or Automatic Eligibility Requirements as described herein.

Eligible *dependents*, at the time of enrollment and throughout the term of *coverage* hereunder, include:

1. A *member's* lawful *spouse*, living within the Service Area serviced by Ambetter; or
2. A *member's* child under the age of 26. For purposes of this provision, the term child shall include a natural child, stepchild, legally adopted child, a child who has been placed for adoption with the *member*, a child under a *member's* permanent guardianship or permanent custody by court order or a child eligible for *coverage* pursuant to a Qualified Medical Child Support Order.

The term *dependent* does not include a *member's* natural child for whom legal rights have been given up through adoption or a grandchild of the *member* for whom the *member* does not have court ordered permanent guardianship or custody. Eligibility is not based on any health status related factors.

For purposes of this provision, a child must be younger than 26 years of age as of the date of adoption or placement for adoption. The term *dependent* does not include a *member's* natural child for whom legal rights have been given up through adoption, or a grandchild of the *member* for whom the *member* does not have court ordered permanent guardianship or custody. Eligibility is not based on any health status related factors.

Attainment of the age of 26 by a *dependent* child shall not operate to terminate the *coverage* of that child while the child is and continues to be both incapable of self-sustaining employment by reason of intellectual disability or physical handicap and chiefly *dependent* on the policyholder for support and *maintenance*. Proof of such incapacity and dependency shall be furnished to Ambetter from Arizona Complete Health by the policyholder within thirty-one days of the child's attainment of 26 years of 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 age of 26.

Enrollment Requirements
The *member* is responsible for submitting a completed and signed Enrollment Application when requesting *coverage* hereunder for himself and any eligible *dependents*. The *member* will be informed whether the Enrollment Application is approved for *coverage*. If the Enrollment Application is approved, the applicant will be notified of the amount of required premium payment and the *effective date* of *coverage* under this Health Plan. Eligibility is not based on any health stat*us* related factors. Please note that *you* may enroll in a plan (or switch enrollment to another plan) only during certain enrollment periods as described below.

An individual or family whose application has been accepted through the *Federally Facilitated Marketplace* are covered under this plan. For more information on how to enroll, please visit https://www.healthcare.gov/. Please note that *you* may enroll in a plan (or switch enrollment to another plan) that is provided through the *Federally Facilitated Marketplace* only during certain enrollment periods as described below.

Open Enrollment Period: The open enrollment period is November 1st through December 15th. During this time *you* can makes changes to *your coverage*.

Special Enrollment Period:
For Health Insurance Marketplace plans, a qualified individual has 60 days to report a qualifying event to the Health Insurance Marketplace and could be granted a 60 day Special Enrollment Period as a result of one of the following events (Note, non-Health Insurance Marketplace plans must report qualifying events to *us*):

- A qualified individual or dependent loses minimum essential coverage, non-calendar year group or individual health insurance coverage, pregnancy-related coverage, access to healthcare services through coverage provided to a pregnant *enrollee*'s unborn child, or medically needed coverage;
- A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order;
    - In the case of marriage, at least one spouse must demonstrate having minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage.
- An individual, who was not previously a citizen, national, or lawfully present individual, gains such status;
- An individual who is no longer incarcerated or whose incarceration is pending the disposition of charges;
- 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;
- An *enrollee* adequately demonstrates to the Health Insurance Marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its *contract* in relation to the *enrollee*'s decision to purchase the qualified health plan based on plan benefits, service area or premium;
- An individual is determined newly eligible or newly ineligible for *advanced premium tax credit* or has a chance in eligibility for *cost sharing* reductions, regardless of whether such individual is already enrolled in a qualified health plan;
- A qualified individual or *enrollee* gains access to new qualified health plans as a result of a permanent move;
- Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
- The qualifying events for employees are:
- Voluntary or involuntary termination of employment for reasons other than gross misconduct; or
- Reduction in the number of hours of employment.
- The qualifying events for spouses are:
- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct;
- Reduction in the hours worked by the covered employee;
- Covered employee's becoming entitled to *Medicare*;
- Divorce or legal separation of the covered employee; or
- Death of the covered employee.

- The qualifying events for dependent children are the same as for the spouse with one addition:
- Loss of dependent child status under the plan rules.
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- A qualified individual or *enrollee* demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide;
- A qualified individual or dependent is a victim of domestic abuse or spousal abandonment and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
- A qualified individual or dependent is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 days after the qualifying event;
- At the option of the Health Insurance Marketplace, a qualified individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a qualified health plan through the Health Insurance Marketplace following termination of Marketplace enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence;
- A qualified individual newly gains access to an employer sponsored individual coverage HRA or a Qualified Small Employer Health Reimbursement Arrangement (HRA).

Enrollment of Newly Eligible Dependent
Dependents of the *member* who become eligible for *coverage* after the *member's* original *effective date* must submit an Enrollment Application requesting *dependent coverage*. The *member* will be notified of *coverage approval*, the amount of required premium payment and the *effective date* of *coverage* for such *dependent*.

Enrollment of Newborn, Adopted Child or Child Placed for Adoption
A newborn child, of a covered mother, a legally adopted child of a covered *enrollee*, or child placed for adoption with the *member* is automatically covered under this *policy* for the first 31 days following the date of birth, date of adoption or placement for adoption. To continue *coverage* after the first 31 days, the *member* must submit an Enrollment Application for such *dependent* within 60 days of the date of birth, date of adoption or placement for adoption. Failure to enroll a newborn within 60 days following the date of birth will terminate *coverage* at the end of the initial 31 day period. The continued *coverage* of the newborn after the initial 31 day period is subject to *our* receipt of premium payment for such newborn. The newborn will show as an active *enrollee* from the date of birth, adoption, or placement for adoption.

Does not include a person who is a *member*'s natural child for whom legal rights have been given up through adoption, or a grandchild of the *member* for whom the *member* does not have court ordered permanent guardianship or custody.

For All Members
A *member's* eligibility for *coverage* under this *contract* will continue until the earlier of:
1. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *contract* or the date that *we* have not received timely premium payments in accordance with the terms of this *contract*; or
2. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or

3. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision; or
4. The date of a *member's* death; or
5. The primary *member* residing outside the Service Area or moving permanently outside the Service Area of this plan; or
6. The date of termination that the Marketplace provides us upon *your* request of cancellation to the Marketplace, or if *you* enrolled directly with *us*, the date *we* receive a request from *you* to terminate this *contract*, or any later date stated in *your* request.

Loss of Dependent Eligibility
A *dependent* whose *coverage* is terminated due to the *member's* death or due to the *member's* dissolution of marriage may convert a *dependent* membership to a new policy, provided such *dependent* meets the eligibility requirements, submits a completed and signed Enrollment Application within 60 days of the date *dependent* is terminated, and submits the required premium payment. The *dependent* will not be required to furnish evidence of insurability, but *coverage* shall be in accordance with the rules and regulations that may have in effect at the time such *dependent* applies for individual *coverage*. Such rules and regulations may include those relating to *coverage*, amount of premium payment, and all other terms and conditions governing individual membership.

A *dependent member* will cease to be a *member* at the end of the premium period in which they cease to be *your dependent member* due to divorce or if a child ceases to be an *eligible child*. For *eligible children*, *coverage* will terminate at 11:59 p.m. on the last day of the year the *dependent* reaches the limiting age of 26. All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*.

A *member* will not cease to be a *dependent eligible child* solely because of age if the *eligible child* is:
1. Incapable of self-s*us*taining employment due to mental handicap or physical handicap that began before the age limit was reached; and
2. Mainly Dependent on the primary *member* for support.

Effective Dates of Coverage
Subject to the eligibility and enrollment requirements *coverage* under this *policy*, shall become effective on the following dates:
1. For the *member* and any enrolled *dependent* whose Enrollment Application has been approved by Ambetter or the *Federally Facilitated Marketplace*, *coverage* shall commence on the date stated in Ambetter or the *Federally Facilitated Marketplace's* written approval letter;
2. For newly eligible *dependents* who become eligible after the *member's* original *effective date* of this *policy*, *coverage* shall be effective as follows:
    a. Newborns of covered *members* are automatically enrolled for the first 31 days from the date of birth. Continued *coverage* beyond the first 31 days is subject to receipt of a signed Enrollment Application and payment of additional premium, if required;
    b. Adopted children of a covered parent are automatically enrolled for the first 31 days following date of adoption. Continued *coverage* beyond the first 31 days is subject to receipt of a signed Enrollment Application and payment of additional premium, if required;
    c. Other eligible *dependents*, as defined in this *policy*, will be enrolled from the date specified in a letter approving enrollment and payment of additional premium if required.

Newborn coverage and cost sharing does not include a person who is a member's natural child for whom

legal rights have been given up through adoption, or a grandchild of the member for whom the member does not have court ordered permanent guardianship or custody.

Please refer to the Newborn Charges section of this *contract* for *cost sharing* information.

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

1. The qualified individual has not been determined eligible for *advanced premium tax credit* or *cost sharing reductions*; or
2. The qualified individual pays the entire premium for the first partial month of *coverage* as well as all *cost sharing*, thereby waiving the benefit of *advanced premium tax credit* 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 2 days of *your effective date* so *we* can review and authorize *medically necessary* services. If services are at a non-contracted *hospital*, claims will be paid at the Ambetter allowable rate.

Change in Status – Notice Required

The *member* is responsible for notifying Ambetter or the *Federally Facilitated Marketplace* of any changes that affect their eligibility, or that of their enrolled *dependents*, for services and benefits under this *Policy*. The *member* must notify Ambetter or the *Federally Facilitated Marketplace* within 60 days of the event. This includes changes of address, addition or deletion of *dependents* resulting from death, achieving the limiting age, and changes in Dependent Disability or Dependent status. *Coverage* for ineligible *members* will terminate in accordance with the termination provisions described in this *Policy*.

PREMIUM PAYMENTS

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

We will notify *you* 31 days in advance for any rate changes, subject to all regulatory requirements. Notices under this provision will be mailed to the *member's* address of record. *We* also reserves the right to modify or amend this *policy* and will provide 60-day advance notice to *enrollees* before the *effective date* of any material modification. Receipt of premium payments made by the *member* shall constitute acceptance of the modification or amendment.

Grace Period
The *member's* failure to make premium payment prior to expiration of the *grace period* defined herein shall be ca*us*e for automatic termination of *coverage* under this *policy*. The date of termination will be the last day of the month for which premium payments have been received in full and accepted by *our* Accounts Receivable Department.

When a *member* is receiving a premium subsidy:
After the first premium is paid, a *grace period* of 3 months from the premium due date is given for the payment of premium. *Coverage* will remain in force during the *grace period*. If full payment of premium is not received within the *grace period*, *coverage* will be terminated as of the last day of the first month during the *grace period*, if *Advance Premium Tax Credits* are received.

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

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

Return of Premium for Ineligible *Enrollees*
If Ambetter receives a premium for an individual or a *member's family member* whom Ambetter determines does not satisfy the eligibility and enrollment requirements, *we* will refund those amounts applicable to the

ineligible *enrollee*. Ineligible *enrollees* are not *members* of this *health plan* and shall have no right to *covered services* under this *policy*.

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

1. Ryan White HIV/AIDS Program under Title XXVI of the Public Health Services 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 relationship, or affiliation with providers of *covered services* and supplies on behalf of *members*, where eligibility is determined based on defined criteria without regard to health status and where payments are made in advance for a coverage period from the effective date of eligibility through the remainder of the calendar year.

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

Renewal
Subject to the provisions governing payment of premiums, this *policy* shall automatically renew for which premiums are being made.

With the exception of non-payment of premium or loss of eligibility, if *we* decide to terminate or non-renew this *contract* for any of the reasons set forth in this *contract*, *we* will give the *member* at least forty-five (45) days advance written notice prior to renewal.

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

Change or Misstatement of Residence
If *you* change *your* residence, *you* must notify the *Federally Facilitated Marketplace* (Note, non-Health Insurance Marketplace plans must notify *us* directly) of *your* new residence within 60 days of the change. As a result *your* premium may change and *you* may be eligible for a *Special Enrollment Period*. See the section on *Special Enrollment Periods* for more information.

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

TERMINATION

Termination of Coverage:
This *policy* may be terminated by *us* upon occurrence of any of the following:

1. If premium payments for the *member* and enrolled *dependents* are not received within the *grace period* defined in this *policy*, *coverage* may automatically terminate. The date of termination will be the last day of the month for which premium payments have been received and accepted by *our* Accounts Receivable Department. Refer to the *Reinstatement* heading for further information on how to re-enroll.
2. If a *member* performs an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact under the terms of this *policy*, *coverage* for that individual may be terminated. Notice of termination will be provided by *us* and mailed to the *member's* address of record. Acts of fraud or intentional misrepresentation include the following:
    1. knowingly furnishing incorrect or incomplete information to *us* in order to obtain benefits for the *member*, enrolled *dependents*, or a non-enrolled individual; or
    2. allowing another person to *us*e *your* identification card, or allowing a *member* to *us*e another person's card.

    An individual whose *coverage* is terminated under this provision will be prohibited from enrolling under any plan offered by *us* in the individual market. If a *member's coverage* is terminated under this provision, their enrolled *dependents* may apply for *coverage* under their own individual plan.
3. If *we* discontinue *coverage* for this particular *health plan* in the State of Arizona, coverage under this *policy* will terminate. A 90 day written notice of termination will be provided by *us* and mailed to the *member's* address of record. The *member*, and their enrolled *dependents*, will have the option of purchasing other health insurance offered by Ambetter in the individual market.
4. If *we* cease to offer *coverage* in the individual market in the State of Arizona, *coverage* under this *policy* will terminate. A 180 day written notice of termination will be provided by *us* and mailed to the *member's* address of record.
5. If a *dependent* fails to meet the eligibility requirements, coverage for that *dependent* will terminate without further notice to *member*. The *effective date* for termination under this *policy* will be the last day of the month in which the qualifying event occurred.
6. *Coverage* will terminate on the date *we* receive a request from *you* to terminate this Evidence of Coverage or any later date stated in *your* request, or if *you* are enrolled through the *Marketplace*, the date of termination that the *Marketplace* provides *us* or *we* provide the *Marketplace*.

We are not responsible for the cost of health care services received by a *member* after the date of termination. If a *member* is confined in a *hospital* or other *inpatient* Facility on the date of termination, *coverage* will cease on that date, except as specifically stated as otherwise herein.

If a *member* elects to terminate *coverage* hereunder, and accepts *coverage* under another health plan, *we* will pay expenses for that *member* until midnight on the date the *member's coverage* is scheduled to terminate.

Cancellation
A *member* desiring to cancel this *policy* shall provide advance written notice to the *Federally Facilitated Marketplace*, or if an off-exchange *member* by written notice to *us*. Benefits under this *policy* shall terminate for all *members* on the last day of the month for which cancellation has been requested, or on the last day of the month for which premium payments have been received by *us*, whichever first occurs. In no

event will a request for cancellation be processed retroactive to the date for which premium payment has been received and accepted by *our* Accounts Receivable Department. Cancellation of *membe*r's membership will also terminate coverage for a *member's* enrolled *dependents*.

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

Loss of Dependent Eligibility
A *dependent* whose *coverage* is terminated for loss of eligibility may apply for *coverage* under their own individual plan, provided such *dependent* meets the *member* eligibility requirements, submits a completed and signed Enrollment Application to the *Federally Facilitated Marketplace*, for Marketplace overage, or to *us*, for off-exchange *coverage*, within 60 days of the termination date of *coverage* hereunder, and submits the required premium payment to *us*. *Coverage* shall be in accordance with the rules and regulations that may have in effect at the time such *dependent* applies for individual *coverage*. Such rules and regulations may include those relating to *coverage*, amount of premium payment, and all other terms and conditions governing individual membership. Enrollment Applications which are submitted more than 60 days following *dependent's* termination will be subject to Open and *Special Enrollment Periods* and will have an *effective date* in accordance with the rules and regulations in effect at the time of *coverage* approval.

Rescission of Coverage
We may rescind this *policy* for any fraudulent or intentional omission or intentional misrepresentation of material facts in the written information submitted by *you* or on *your* behalf on or with *your* enrollment application.

A material fact is information which, if known to *us*, would have caused *us* to decline to issue coverage. If this *policy* is rescinded, *we* shall have no liability for the provision of coverage under this *policy*.

By signing the enrollment application, *you* represented that all responses to the Statement of Health were true, complete and accurate, to the best of *your* knowledge, and that should *we* accept *your* enrollment application, the enrollment application would become part of the *policy* between *us* and *you*. By signing the enrollment application *you* further agreed to comply with the terms of this *policy*.

If *we* make a decision to rescind *your* coverage, such decision will be first sent for review to an independent third party auditor contracted by *us*.

If this *policy* is rescinded, *we* will provide a written notice that will:
1. Explain the basis of the decision and *your health care appeal* rights;
2. Clarify that all *members* covered under *your coverage* other than the individual whose coverage is rescinded may continue to remain covered; and
3. Explain that *your* monthly premium will be modified to reflect the number of *members* that remain under this *policy*.

If this *policy* is rescinded:

1. *We* may revoke *your coverage* as if it never existed and *you* will lose health benefits including *coverage* for treatment already received;
2. *We* will refund all premium amounts paid by *you*, less any medical expenses paid by *us* on behalf of *you* and may recover from *you* any amounts paid under the *policy* from the original date of coverage; and
3. *We* reserve ours right to obtain any other legal remedies arising from the rescission that are consistent with Arizona law.

If *your coverage* is rescinded, *you* have the right to appeal *our* decision to rescind such *coverage*.

Reinstatement

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

CLAIMS

How to file a claim for Covered Services – Network Providers
Network Providers, also known as In-Network Providers, will file *claims* on *your* behalf with *us* for *covered expenses*. Present *your* identification card at the time of service. Payment for *covered expenses* will be made directly to the *network provider*. *You* will be responsible for *copayment*, *deductibles*, *coinsurance* amounts, any non-Covered or Excluded Expenses, and amounts over specifically limited benefits. Please refer to the Provider Directory for a list of *network providers*.

How to File a Claim for Covered Services - Non-Network Providers
In the case of a medical *emergency* or as *authorized* by Ambetter, *you* may need to get care from *non-network providers*. *Providers* who do not have an agreement with *us,* may or may not file *your claim* with *us*. If they do not, send a copy of *your* paid itemized bill to *us*, along with a completed *claim* form which can be obtained from *our* website. Payment of the billed expense amount for *covered services*, as defined in this *policy*, will be paid to *you* subject to applicable *copayment*s, *deductibles* and *coinsurance* amounts, unless *we* are directed otherwise, or as required by applicable state or federal law. *You* will be responsible for *copayment*s, *deductibles*, *coinsurance* amounts, any non-covered or excluded expenses, and amounts over specifically limited benefits.

Claims should be addressed to:

Ambetter from Arizona Complete Health
ATTN: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

Payment of Claims
Time of payment of *claims*: Payment payable under this *policy* for any claim for which this *policy* provides any periodic payment, will be paid immediately upon receipt of due written proof of allowed services. Subject to due written proof of allowed services, all accrued payments for services for which this *policy* provides periodic payment will be paid, and any balance remaining unpaid upon the termination of liability will be paid upon receipt of written proof of allowed services, subject to terms of the *contract*. Providing all information that is necessary to process a *claim* has been received, *claims* will be processed within 30 calendar days of receipt.

Physical Examination and Autopsy
We have the right to have any *member* examined at *our* expense while a *claim* is pending payment. *We* also have the right to have an autopsy performed where it is not prohibited by law. These examinations are made at *our* expense and as often as *we* may reasonably require.

Double Coverage
If an individual is both enrolled as a *member* under this *policy*, and entitled to benefits under any other coverage described below, *our* responsibility for services and supplies provided to the *member* for the treatment of any one illness or injury shall be reduced by the amount of benefits paid for the treatment of that same illness or injury, which resulted from the *member*'s payment for such services and supplies from any other source.

This provision is applicable to any service and supplies, including room and board, provided to the *member* by any municipality, county, federal or state governmental agency or other political subdivision. This provision shall not apply to:

a. Any medical assistance benefits and services to which a *member* is entitled pursuant to the Arizona medical assistance program; or
b. *Covered Services* received by a veteran *member* in a Veterans Administration or armed forces facility as required by federal law.

Right to Receive and Release Information
We may release or receive any information considered to be necessary for *us* to coordinate benefits with respect to any person claiming benefits under this *policy* and without any additional consent, or notice to, the *member* or any other person or organization. *We* shall not, however, be required to determine the existence of any other group *payor* or insurer or the benefits payable under such *payor* or insurer when computing *covered services* due a *member* under this *policy*.

Recovery of Overpayment
If the *covered services* provided by *us* exceed the total amount of benefits that should have been paid under this section, *we* have the right to recover from one or more of the following:
1. Any person to or from whom such payments were made; or
2. Insurance companies.

Facility of Payment
Payment(s) made under another Plan, which included amounts that should have been paid by *us*, shall be reimbursed to that entity and treated as though it was a benefit paid under this Plan. *We* will not be required to pay that amount again. The term *payment(s) made* shall include providing benefits in the form of services, in which case *payment(s) made* will be interpreted as the reasonable cash value of the benefits provided in the form of services.

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*. All sums payable under such programs for services provided shall be payable to and retained by *us*. Each *member* shall complete and submit to *us* such consents, releases, assignments and other documents as *we* may request in order to obtain or assure reimbursement under *Medicare* or any other government program for which *members* are eligible. In cases where *Medicare* or another government program (excluding Arizona AHCCCS) has primary responsibility, *Medicare* benefits will be taken into account for any *member* who is enrolled for *Medicare*. This will be done before the benefits under this *health plan* are calculated.

In cases where *Medicare* or another government program (excluding Arizona AHCCCS) has primary responsibility, *Medicare* benefits will be taken into account for any member who is enrolled for *Medicare*. This will be done before the benefits under this *health plan* are calculated.

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.

Any rules for coordination of benefits will be applied after benefits have been calculated under the rules in this provision. The allowed amount, which is either the contracted amount or the *Medicare* allowed amount (whichever is less) will be reduced by any *Medicare* benefits available for those expenses.

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.

Health Care Liens
When there is a source of payment for a *covered service* in addition to the *coverage* provided by *us*, such as, for example, a liability insurer, government payer or uninsured and/or underinsured motorist coverage *network providers* may collect from that other source any difference between the negotiated amount of payment agreed upon between *us* and the *network provider* for a *covered service* and the *network provider's* customary charge, by following the procedures set forth in Arizona law (A.R.S. Sec. 33-931).

Worker's Compensation
The benefits which a *member* is entitled to receive under this *policy* are not designed to duplicate any benefits to which the *member* is entitled under workers' compensation law. *We* are entitled to reimbursement for any services that have been reimbursed under a workers' compensation claim.

1. *Member* is required to file for workers' compensation when an employment related *accident*, *illness* or *injury* occurs.
2. If the *member's* workers' compensation carrier denies a claim, the *member* may submit the claim to *us* with a copy of the denial for consideration under this *policy*. All plan provisions of this *policy* will apply in the consideration process for payment under this plan.
3. Workers' compensation claims that are not a benefit under this *policy* are not payable by *us*.
4. Any benefits payable are subject to all provisions of this *policy*, including but not limited to the *authorization* requirements.

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.

COMPLAINT, GRIEVANCE, HEALTH CARE APPEALS AND EXTERNAL REVIEW PROCEDURES

YOUR SATISFACTION IS OUR CONCERN

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.

You may, on occasion, be dissatisfied with quality of care, service issues, or the denial of a *claim* or request for service. Below is a brief description of each process. Please see *your* separate information package titled *Arizona Complete Health Care Appeals Process Information Packet* for a full description of the Appeal process including the different levels of appeal available to *you.*

Anytime *you* have a concern about the quality of care *you* receive, the level of *our* service or any other aspect of *your health plan* experience, *we* want to know. Call *us* toll free at 1-888-926-5057 (TTY: 711). Many times, a single phone call to Member Services staff can address your concerns.

In addition to calling Member Services, there are other avenues for *you* to use if *you* do not agree with a decision made by *us* or by one of the health care professionals who work with *us*. Like *you*, *we* want to be sure the appropriate decisions are made regarding *your* medical care and that *you* receive the benefits *your health plan* covers.

THE ROLE OF THE DIRECTOR OF THE ARIZONA DEPARTMENT OF INSURANCE

The Director of the Arizona Department of Insurance oversees this appeals process. The Director maintains a copy of each health plan's *utilization review* policy; receive, process, and act on requests from health plans for External Independent Review; review and enforce or overturn the decisions of the health plans; and file appropriate reports with the Arizona Legislature. In instances where the Director is sometimes unable to determine issues of coverage, they forward the case to the independent review organization (IRO) to complete a review within 21 days of receipt. The Director has five business days after receiving the IRO's decision to send the decision to *you*, *your* treating *provider* and *us*. When necessary, the Director must transmit appeal records to the Superior Court or the Office of Administrative Hearings and issue final administrative decisions.

SHOULD YOU FILE A COMPLAINT OR A HEALH CARE APPEAL?

Complaint

You initiate a *complaint* when *you* are not satisfied with the quality of care or service *you* are receiving. A *complaint* is the step *you* take to tell *us* that *we* are not meeting *your* expectations. A *complaint* tells *us* that *you* are not pleased with the quality of medical care or the service that *you* received. A *complaint* brings *your* concern to *our* attention.

We want *you* to let *us* know how *we* can improve any aspect of *your* medical care, preventive health benefits, customer service or *your* understanding of *your* health plan. Call, write or fax *your* complaint to *us* within 180 calendar days. *We* will acknowledge receiving *your complaint* within five (5) business days. *You* will receive a decision within 60 calendar days. Occasionally, *we* may need additional time to review *your*

issue. *We* will send written information explaining *our* need for additional time to review *your* issue. *We* will not extend *our* review time beyond fifteen (15) additional calendar days. Every *complaint* about the quality of medical care is taken seriously. That's why we have a Quality Improvement Department for investigation and follow-up with the doctor or *facility* that provided the care. Quality of Concern related *complaint* reviews are part of a confidential process so *we* may not be able to give detailed outcome information; however, *we* will communicate to *you* when the case has been open, and resolved.

To file a *complaint*, *we* can be contacted Monday through Friday from 8 a.m. to 5 p.m. at 1-888-926-5057 (TTY: 711).

Arizona law requires *us* to provide *you* with a way to appeal any denied claims or denied services. A "denied claim" is when *you* have already received care, submitted a claim, and *we* have denied the claim.

A "denied service" is when Arizona Complete Health refuses to authorize a service that is covered, such as a referral to a specialist, or if *we* deny a pre-authorization request for a treatment or procedure that *you* or *your* doctor believe is *medically necessary* and covered by *your policy*.

When *we* deny a claim or service, *we* will advise *you* of *your* right to appeal the denial. The appeals process **does not** occur unless *you,* someone *you* designate (including an attorney), or *your provider* has specifically requested that *we* reconsider *our* decision. The appeals process consists of the following levels of review:

For urgently needed services not yet provided:

Level 1: Expedited Medical Review: *You* may request an Expedited Medical Review for the denial of a service not already provided if *we* denied *your* request for a covered service and *your* treating *provider* certifies in writing and provides supporting documentation that the Level 1 Informal Reconsideration and Formal Appeal process (about 60 days) is likely to cause a significant negative change in *your* medical condition.

We have one (1) business day after receiving the information from the treating *provider* to decide whether *we* should change *our* decision and authorize the requested service.

Please note: If the expedited appeal request does not include the treating *provider* certification, *we* review the appeal under the standard Level 1 process.

Level 2: Expedited Appeal (optional): If *we* deny *your* request at Level 1, *you* may request a Level 2 Expedited Appeal. After *you* receive *our* Level 1 denial, *your* treating *provider* must immediately send *us* a written request to tell *us you* are appealing to Level 2. To help *your* appeal, *your provider* should send *us* any additional information (that the *provider* has not already sent *us*) to show why *you* need the requested service.

Within three (3) business days after receiving the request for an expedited appeal, *we* shall provide notice of the expedited appeal decision.

Level 3: Expedited External, Independent Review: *You* may appeal to Level 3 only after *you* have appealed through Level 1. *We* will acknowledge receiving *your complaint* within one (1) business day. *You* have five (5) business days after *you* receive *our* Level 1 or Level 2 decision to send *us your* written request for Expedited External Independent review.

For non-urgent services (pre-service) or denied *claims* for payment (post service):

Level 1: Informal Reconsideration: (Pre-service only) *You*, or *your* treating *provider*, have two (2) years from the initial denial to request a Level 1 Informal Reconsideration of *your* denied request for a service if *we* denied *your* request for a covered service and *you* do not qualify for an expedited appeal.

We have five (5) business days after *we* receive *your* request for a Level 1 Informal Reconsideration review request to send *you* and *your* treating *provider* a notice that *we* received *your* request.

We have 30 days after the receipt date to decide whether *we* should change *our* decision and authorize *your* requested service. Within that same 30 days, *we* send *you* and *your* treating *provider our* written decision.

Please note: Claim for covered service already provided but not paid: *You* may not request a Level 1 Informal Reconsideration of *your* denied request for the payment of a covered service. Instead, *you* may start the review process by seeking a Level 2 Formal Appeal.

Level 2: Formal Appeal (optional): *You* may request a Level 2 Formal Appeal if *we* deny *your* Level 1 Informal Reconsideration (Pre-Service) or to dispute an unpaid (denied) *claim* payment.

For Pre-Service appeals, *you, your* designee, or *your* treating *provider* have 60 days after *you* receive *our* Level 1 denial, to send *us* a written request to appeal to Level 2 or Level 3. *We* will acknowledge receiving *your complaint* within five (5) business days. *We* have 30 days from the receipt date to decide if *we* should change *our* decision and authorize the requested services. *We* will not extend *our* review time beyond fifteen (15) additional calendar days.

For post-service appeals, *you* have 2 years from *our* initial denial notice to request a Level 2 Formal Appeal. *We* will acknowledge receiving *your complaint* within five (5) business days. *We* have 60 days from the receipt date to decide if *we* should change *our* decision and authorize the requested services. *We* will not extend *our* review time beyond fifteen (15) additional calendar days.

Level 3: External, Independent Review: *You* may request a Level 3 review only after *you* have appealed through Level 1. *You* have four (4) months after *you* receive *our* Level 1 or Level 2 decision to send *us your* written request for External Independent Review.

Neither *you* nor *your* treating *provider* is responsible for the cost of any external independent review.

There are two types of Level 3 appeals, depending on the issues in *your* case:

1. Medical Necessity Cases: Within five (5) business days of receiving *your* request, *we* mail a written acknowledgement of the request to *you,* the Director of Insurance, and *your* treating *provider.* The following is included in the mailing to the ADOI Director:
    - A copy of *your* request for a Level 3 review;
    - A copy of *your* policy, Evidence of Coverage, or similar document;
    - All medical records and supporting documentation used to render *our* decision;
    - The criteria used and clinical reasons for *our* decision and the relevant portions of *our* utilization review guidelines;
    - The name and credentials of the health care *provider* who reviewed and upheld the denial at the earlier appeal levels.

    Within five (5) business days of receiving *our* information, the Insurance Director sends all the submitted information to an external independent reviewer organization (the "IRO").

    Within 21 days of receiving the packet of information, the IRO makes a decision and sends the decision to the ADOI Director. The Director may extend the review timeframe an additional 31 days for good cause.

    Within five (5) business days of receiving the IRO's decision, the Insurance Director mails a notice of the decision to *you*, *your* treating *provider* and *us.*

    If the IRO decides that *we* should provide the service, *we* will authorize the service. If the IRO agrees with *our* decision to deny the service, the appeal is over. *Your* only further option is to pursue *your* claim in Superior Court.

2. Contract Coverage Cases: Within five (5) business days of receiving *your* request, *we*:

1. Mail a written acknowledgement of *your* request to the ADOI, *you,* and *your* treating *provider.*
2. Send the Director of Insurance and the *provider* the following:
    - A copy of *your* request for a Level 3 review;
    - A copy of *your* policy, Evidence of Coverage, or similar document;
    - All medical records and supporting documentation used to render *our* decision;
    - A summary of the applicable issues including a statement of *our* decision;
    - The criteria used and clinical reasons for *our* decision and the relevant portions of *our* utilization review guidelines.
    - The name and credentials of the health care *provider* who reviewed and upheld the denial at the earlier appeal levels.

The ADOI Director makes a coverage determination, issues a decision, and sends a written notice to *us*, *you,* and *your* treating *provider* within fifteen (15) business days.

In instances where the Insurance Director is sometimes unable to determine issues of coverage, the ADOI forwards the case to the IRO to complete a review within 21 days of receipt. The Insurance Director has five (5) business days after receiving the IRO's decision to send the decision to *you, your* treating *provider* and *us.*

If *you, your* treating *provider,* or *we* disagree with the ADOI Director's final decision on a contract coverage issue, a request for a hearing with the Office of Administrative Hearings ("OAH") can be filed within 30 days of receiving the Director's decision. OAH schedules and completes a hearing for appeals from Level 3 decisions.

When *we* issue a decision in response to *you* or *your* treating *provider's* original request for service, or payment, *we* include information on the next level of appeal available to *you,* including filing instructions and contact information.

Please refer to *your Arizona Complete Health Care Appeals Process Information Packet* for detailed information on all levels of the appeal process. The *Arizona Complete Health Care Appeals Process Information Packet* was delivered with *your policy.* If *you* need another packet mailed to *you*, please contact *us* Monday through Friday from 8 a.m. to 5 p.m. at 1-888-926-5057 (TTY: 711).

TO GET STARTED

Phone

You can initiate an expedited *health care appeal* or *grievance* process by phone. Just call Member Services *us*, Monday through Friday from 8 a.m. to 5 p.m. at 1-888-926-5057 (TTY: 711).

Mail
You MUST file standard *health care appeals* in writing to:

Ambetter from Arizona Complete Health.
Ambetter Appeals and Grievance Dept.
P.O. Box 277610
Sacramento, CA 95827

Fax
You may also fax a written *health care appeal* to the Ambetter Appeals and Grievance Department at 1-877-615-7734.

OTHER COMPLAINT & APPEAL INFORMATION

General Eligibility Standard Appeals and Premium Disputes

We do not review any disputes regarding eligibility and/or premiums for policies purchased through the *Marketplace*. However, under Federal law, *you* and *your* health care decision-maker have the right to file a dispute within a reasonable timeframe regarding *your* eligibility, which may include a determination of *your* eligibility for an enrollment period, including for *Special Enrollment Periods*. *You* may also file any disputes regarding *your* premiums or premium assistance directly to the *Marketplace*.

You may contact the *Marketplace* by telephone at 1-800-318-2596 or 1-855-889-4325 (TTY: 711), which is available 24 hours a day, 7 days a week or online at https://www.healthcare.gov/marketplace-appeals/appeal-forms/. *You* may send *your* written appeal by fax to 1-877-369-0130 or by mail to:

Health Insurance Marketplace
ATTN: Appeals
465 Industrial Boulevard
London, KY 40750-0061

After the Marketplace reviews *your* dispute and *you* do not agree with their decision, *you* have an additional right to appeal that decision through the U.S. Department of Health and Human Services (HHS). *You* must file *your* dispute to the HHS within 30 days of the Marketplace's notice to *you* of their dispute decision. *You* may contact the HHS at their Toll Free Call Center: 1-877-696-6775.

You may find additional information regarding *your* appeal rights through the Marketplace's website at: https://www.healthcare.gov/contact-us/ and/or through the HHS' website at https://www.hhs.gov/healthcare/index.html.

Getting Your Medical Records
Under Arizona law, *you* and *your* health care decision-maker are entitled to a copy of *your* medical records from any health care professional that has treated *you*. Make *your* request in writing and be sure to include the address where *you* want *your* records sent. In some cases, *your* records will be sent only to the medical professional that *you* have designated.

Confidential Medical Information
Your medical records are confidential. They are used only as needed to make decisions about *your* care – or any appeals *you* may file. During an appeal, Arizona Complete Health may release some portions of *your* medical records to the people who are reviewing *your* case.

Mailing Documents
We wants to be sure *our* response reaches *you*. Please confirm that *we* have *your* current mailing address in *our* records because that is where documents will be sent. *We* consider information mailed to *you* to be received on the fifth business day.

Questions
If *you* have questions or need assistance, please call Member Services at 1-888-926-5057 (TTY: 711).

Medical Malpractice Disputes
Any disputes alleging the medical malpractice, negligence and/or wrongful act of a health care *provider*, or *injury* or property damage caused as a result of an *accident* at the premises of a health care *provider*, shall not include *us* and shall include only the *provider* subject to the allegation. Ambetter from Arizona Complete Health, and Plan *providers* are independent contractors in relation to one another.

Access to Medical Records
We are entitled to receive from any *provider* who renders *covered services* to a *member* all information reasonably related to such services. Subject to applicable confidentiality requirements, *members authorize* any *provider* rendering *covered services* to disclose all facts pertaining to the *member's* care and treatment by the *provider* and to permit copying of reports and records by *us*. *Member* agrees to execute a release and/or *authorization* for *us* to obtain medical records if requested by *us* during the term of the *member's coverage*. *We* reserve the right to reject or suspend a *claim* based on lack of medical information or records.

Confidentiality
We shall preserve the confidentiality of the *members*' health and medical records consistent with the requirements of applicable Arizona and federal law.

GENERAL PROVISIONS

Entire Agreement
This *policy*, the *Schedule of Benefits*, and the individual Enrollment Application, including any attachments, constitute the entire agreement between Ambetter from Arizona Complete Health and the *member*, and supersede all prior and existing arrangements, understandings, negotiations, and disc*us*sions, whether written or oral, of the parties. There are no warranties, representations, or other agreements between *us* and the *member* in connection with the subject matter of this *policy*, except as specifically set forth herein. No supplement, modification or waiver of this *policy*, other than as specifically provided for herein, shall be valid unless executed in writing by the President of Arizona Complete Health or an authorized executive officer of Arizona Complete Health. No agent has authority to change this *policy* or to waive any of its provisions.

Time Limit on Certain Defenses
After two years from the date of issue of this *policy* no misstatements, except fraudulent misstatements, made by the *member* in the Enrollment Application shall be used to void the *policy* or to deny a *claim* for *loss* incurred or Disability commencing after the expiration of such two year period.

Independent Contractor Services
We do not ourselves undertake to directly furnish any health care services under the agreement. *We* reserve the right to add or delete *network providers* from *our provider* panel.

The relationship between *us* and *network providers*, *physicians*, *Skilled Nursing Facilities*, *networks*, other *health professionals*, and other community agencies, is that of independently contracting entities. Such independently contracting entities are neither agents nor employees of Arizona Complete Health nor is Arizona Complete Health or any employee of Arizona Complete Health an employee or agent of such entities. *We* shall not be liable for any *claim*, demand or cause of action regarding damages arising out of, or in any manner connected with, any injuries, alleged or otherwise, suffered by the *member* while receiving care in, from, or through any such entities.

Acceptance Of The Agreement
The *member* enters into this Agreement on behalf of himself and any enrolled *dependents* who become *members* of Ambetter. Acceptance of this *policy* by the *member* constitutes acceptance by their enrolled *dependents* and is binding on all *members*. By electing medical and *hospital coverage* pursuant to their *policy*, or accepting benefits hereunder, all *members* legally capable of contracting, and the legal representatives of all *members* incapable of contracting, agree to all terms, conditions and provisions of this *policy*.

Amendment or Modification
This *policy* shall be subject to amendment, modification or termination in accordance with the provisions hereof. *We* will provide the *member* 60 day prior written notification of any amendment or material modification to this *policy*, including the *Schedule of Benefits*. Notice will be sent to the *member's* address of record. Receipt of premium payment by will constitute the *member's* acceptance of the amendment or modification. Consent of enrolled *dependents* is not required. The *member's* failure to make premium payment will automatically terminate *coverage* under this *policy*. The date of termination will be the last day for which premium payment has been received and accepted by *our* Accounts Receivable Department.

Policies and Procedures
We have adopted policies, procedures, rules and interpretations to promote orderly and efficient administration of the Agreement, and, in *our* discretion, may Amend, modify, terminate, or adopt other policies, procedures, rules and interpretations. Consent or concurrence of the *member*, or enrolled *dependents*, is not required. At *our* sole discretion and without obligation under this Health Plan, *we* may offer to provide a *member* alternative coverage for services and supplies which may be otherwise excluded or limited by the terms of this *policy*. Such alternative coverage is available only where Ambetter and the *member*, or the *member's* legal representative, agree in writing to the alternative treatment. All alternative treatment is subject to the determination by the *member's* treating *provider* that the alternative treatment plan is appropriate for the *member*. In no event shall the cost of alternative coverage exceed the cost of *covered services* to which the *member* would otherwise be entitled.

Commencement or Termination
Whenever an effective date of commencement or termination is provided, such commencement shall be effective as of 12:01 a.m. of that date in Arizona. Termination shall be effective as of 11:59 p.m. of that date in Arizona.

Policy
We will deliver to each *member* a copy of this *policy*, including the *Schedule of Benefits,* which sets forth the terms and conditions governing the rights of such *member* and *dependents*.

Clerical Inaccuracies
Clerical error by *us* in keeping any record pertaining to *coverage* hereunder, will not invalidate *coverage* otherwise validly in force or continue *coverage* otherwise validly terminated.

Any notice to a *member*, or an enrolled *dependent*, shall be sufficient if the notice is addressed to the *member* at the address last appearing on *our* records.

Assignment
All rights of *members* hereunder are personal to each *member* and are not assignable or otherwise transferable. Neither the Agreement nor any right hereunder shall be assigned, transferred or otherwise conveyed by *us* without the approval of *us*. If a *member* desires to assign any rights hereunder, such request shall be evidenced in writing signed by the *member* and will be granted or denied at *our* sole discretion. Nothing herein shall be construed to prohibit *us* from engaging in a corporate reorganization or merger without the consent of the *member*.

Severability
If any term, provision, covenant or condition of this *policy* is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions shall remain in full force and shall in no way be affected, impaired or invalidated.

Implied Waiver
Failure by *us* on one or more occasion to avail itself of a right conferred by this *policy* shall in no event be construed as a waiver of its right to enforce said right in the future. Should *we* provide a *member* with *coverage* for benefits to which the *member* is not entitled under this *policy*, such provision of *coverage* shall not amend this *policy* to incorporate those benefits herein or entitle the *member* to receive additional benefits not specifically listed under this *policy*.

IMPORTANT NOTICES

Notice of Privacy Practices:

This notice describes how medical information about *you* may be used and disclosed and how *you* can get access to this information. Please review it carefully.

For help to translate or understand the Notice of Privacy Practices, please call 1-888-926-5057 (TTY: 711).

Si necesita ayuda para traducir o entender este texto, por favor llame al telefono.
1-888-926-5057 (TTY: 711).
Interpreter services are provided free of charge to you.

Covered Entities Duties:

Arizona Complete Health is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Arizona Complete Health is required by law to maintain the privacy of *your* protected health information (PHI), provide *you* with this Notice of *our* legal duties and privacy practices related to *your* PHI, abide by the terms of the Notice that is currently in affect and notify you in the event of a breach of *your* unsecured PHI.

This Notice describes how *we* may use and disclose *your* PHI. It also describes *your* rights to access, amend and manage *your* PHI and how to exercise those rights. All other uses and disclosures of *your* PHI not described in this Notice will be made only with *your* written authorization.

Arizona Complete Health reserves the right to change this Notice. *We* reserve the right to make the revised or changed Notice effective for *your* PHI *we* already have as well as any of your PHI *we* receive in the future. Arizona Complete Health will promptly revise and distribute this Notice whenever there is a material change to the following:

- The uses and disclosures.
- *Your* rights.
- *Our* legal duties.
- Other privacy practices stated in the notice.

We will make any revised Notices available on the Arizona Complete Health website at https://ambetter.azcompletehealth.com/.

Permissible Uses and Disclosures of Your PHI:

The following is a list of how *we* may use or disclose *your* PHI without *your* permission or authorization:

- Treatment - *We* may use or disclose *your* PHI to a physician or other health care provider providing treatment to *you*, to coordinate *your* treatment among providers, or to assist *us* in making prior authorization decisions related to *your* benefits.
- Payment - *We* may use and disclose *your* PHI to make benefit payments for the health care services provided to *you*. *We* may disclose *your* PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include:
    - processing claims
    - determining eligibility or coverage for claims
    - issuing premium billings
    - reviewing services for medical necessity
    - performing utilization review of claims
- HealthCare Operations - *We* may use and disclose *your* PHI to perform *our* healthcare operations. These activities may include:
    - providing customer services
    - responding to complaints and appeals
    - providing case management and care coordination
    - conducting medical review of claims and other quality assessment
    - improvement activities
- In *our* healthcare operations, *we* may disclose PHI to business associates. *We* will have written agreements to protect the privacy of *your* PHI with these associates. *We* may disclose *your* PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its healthcare operations. This includes the following:
    - quality assessment and improvement activities
    - reviewing the competence or qualifications of healthcare professionals
    - case management and care coordination
    - detecting or preventing healthcare fraud and abuse

Other Permitted or Required Disclosures of *Your* PHI:

- Fundraising Activities – *We* may use or disclose *your* PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If *we* do contact *you* for fundraising activities, *we* will give *you* the opportunity to opt-out, or stop, receiving such communications in the future.
- Underwriting Purposes – *We* may use or disclose *your* PHI for underwriting purposes, such as to make a determination about a coverage application or request. If *we* do use or disclose *your* PHI for underwriting purposes, *we* are prohibited from using or disclosing *your* PHI that is genetic information in the underwriting process.
- Appointment Reminders/Treatment Alternatives - *We* may use and disclose *your* PHI to remind *you* of an appointment for treatment and medical care with *us* or to provide *you* with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose.
- As Required by Law - If federal, state, and/or local law requires a use or disclosure of *your* PHI, *we* may use or disclose *your* PHI information to the extent that the use or disclosure complies with

such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, *we* will comply with the more restrictive laws or regulations.

- Public Health Activities - *We* may disclose *your* PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. *We* may disclosure *your* PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness products or services under the jurisdiction of the FDA.
- Victims of Abuse and Neglect - *We* may disclose *your* PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law authorized by law to receive such reports if *we* have a reasonable belief of abuse, neglect or domestic violence.
- Judicial and Administrative Proceedings - *We* may disclose *your* PHI in judicial and administrative proceedings. *We* may also disclose it in response to the following:
    - an order of a court
    - administrative tribunal
    - subpoena
    - summons
    - warrant
    - discovery request
    - similar legal request
- Law Enforcement - *We* may disclose *your* relevant PHI to law enforcement when required to do so. For example, in response to:
    - court order
    - court-ordered warrant
    - subpoena
    - summons issued by a judicial officer
    - grand jury subpoena
- *We* may also disclose *your* relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.
- Coroners, Medical Examiners and Funeral Directors - *We* may disclose *your* PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. *We* may also disclose *your* PHI to funeral directors, as necessary, to carry out their duties.
- Organ, Eye and Tissue Donation - *We* may disclose *your* PHI to organ procurement organizations. *We* may also disclose *your* PHI to those who work in procurement, banking or transplantation of:
    - cadaveric organs
    - eyes
    - tissues
- Threats to Health and Safety - *We* may use or disclose *your* PHI if *we* believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
- Specialized Government Functions - If *you* are a member of U.S. Armed Forces, *we* may disclose *your* PHI as required by military command authorities. *We* may also disclose *your* PHI:
    - to authorized federal officials for national security
    - to intelligence activities
    - the Department of State for medical suitability determinations
    - for protective services of the President or other authorized persons
- Workers' Compensation - *We* may disclose *your* PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

- Emergency Situations – *We* may disclose *your* PHI in an emergency situation, or if *you* are incapacitated or not present, to a *family member*, close personal friend, authorized disaster relief agency, or any other person previous identified by *you*. *We* will use professional judgment and experience to determine if the disclosure is in *your* best interests. If the disclosure is in *your* best interest, *we* will only disclose the PHI that is directly relevant to the person's involvement in *your* care.
- Inmates - If *you* are an inmate of a correctional institution or under the custody of a law enforcement official, *we* may release *your* PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide *you* with health care; to protect *your* health or safety; or the health or safety of others; or for the safety and security of the correctional institution.
- Research - Under certain circumstances, *we* may disclose *your* PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of *your* PHI.

Uses and Disclosures of *Your* PHI That Require *Your* Written Authorization

We are required to obtain *your* written authorization to use or disclose *your* PHI, with limited exceptions, for the following reasons:

Sale of PHI – *We* will request *your* written authorization before *we* make any disclosure that is deemed a sale of *your* PHI, meaning that *we* are receiving compensation for disclosing the PHI in this manner.

Marketing – *We* will request *your* written authorization to use or disclose *your* PHI for marketing purposed with limited exceptions, such as when *we* have face-to-face marketing communications with *you* or when *we* provide promotional gifts of nominal value.

Psychotherapy Notes – *We* will request *your* written authorization to use or disclose any of *you* psychotherapy notes that *we* may have on file with limited exception, such as for certain treatment, payment or healthcare operation functions.

Individuals Rights

The following are *your* rights concerning *your* PHI. If *you* would like to use any of the following rights, please contact *us* using the information at the end of this Notice.

- Right to Revoke an Authorization - *You* may revoke *your* authorization at any time, the revocation of *your* authorization must be in writing. The revocation will be effective immediately, except to the extent that *we* have already taken actions in reliance of the authorization and before *we* received *your* written revocation.
- Right to Request Restrictions **-** *You* have the right to request restrictions on the use and disclosure of *your* PHI for treatment, payment or healthcare operations, as well as disclosures to persons involved in *your* care or payment of *your* care, such as *family members* or close friends. *Your* request should state the restrictions *you* are requesting and state to whom the restriction applies. *We* are not required to agree to this request. If *we* agree, *we* will comply with *your* restriction request unless the information is needed to provide *you* with emergency treatment. However, *we* will restrict the use or disclosure of PHI for payment or health care operations to a health plan when *you* have paid for the service or item out of pocket in full.

- Right to Request Confidential Communications - *You* have the right to request that *we* communicate with *you* about *your* PHI by alternative means or to alternative locations. This right only applies if the information could endanger *you* if it is not communicated by the alternative means or to the alternative location *you* want. *You* do not have to explain the reason is for *your* request, but *you* must state that the information could endanger *you* if the communication means or location is not changed. *We* must accommodate r request if it is reasonable and specifies the alternative means or location where PHI should be delivered.
- Right to Access and Received Copy of *your* PHI - *You* have the right, with limited exceptions, to look at or get copies of *your* PHI contained in a designated record set. *You* may request that *we* provide copies in a format other than photocopies. *We* will use the format *you* request unless *we* cannot practicably do so**.** *You* must make a request in writing to obtain access to *your* PHI. If *we* deny *your* request, *we* will provide *you* a written explanation and will tell *you* if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.
- Right to Amend *your* PHI - *You* have the right to request that *we* amend, or change, *your* PHI if *you* believe it contains incorrect information. *Your* request must be in writing, and it must explain why the information should be amended. *We* may deny *your* request for certain reasons, for example if *we* did not create the information *you* want amended and the creator of the PHI is able to perform the amendment. If *we* deny *your* request, *we* will provide *you* a written explanation. *You* may respond with a statement that *you* disagree with *our* decision and *we* will attach *your* statement to the PHI *you* request that *we* amend. If *we* accept *your* request to amend the information, *we* will make reasonable efforts to inform others, including people *you* name, of the amendment and to include the changes in any future disclosures of that information.
- Right to Receive an Accounting of Disclosures - *You* have the right to receive a list of instances within the last 6 years period in which *we* or *our* business associates disclosed *your* PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures *you* authorized and certain other activities. If *you* request this accounting more than once in a 12-month period, *we* may charge *you* a reasonable, cost-based fee for responding to these additional requests. *We* will provide *you* with more information on *our* fees at the time of *your* request.
- Right to File a Complaint - If *you* feel *your* privacy rights have been violated or that *we* have violated *our* own privacy practices, *you* can file a complaint with *us* in writing or by phone using the contact information at the end of this Notice.

You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-800-368-1019, (TTY: 1-866-788-4989) or visiting https://www.hhs.gov/hipaa/filing-a-complaint/what-to-expect/index.html.

Contact Information

If *you* have any questions about this Notice, *our* privacy practices related to *your* PHI or how to exercise *your* rights *you* can contact *us* in writing or by phone using the contact information listed below.

Arizona Complete Health
Attn: Privacy Official
1870 E. Rio Salado Parkway, Suite 2A
Tempe, AZ 85281
1-888-926-5057

How to Report Fraud and Abuse

If you suspect one of *our providers* or *members* of fraud and abuse, please contact Arizona Complete Health toll-free Fraud and Abuse Hotline at 1-800-977-3565. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

Women's Health and Cancer Rights Act of 1998:

Surgical services for breast reconstruction and for post-operative prostheses incidental to a *medically necessary* mastectomy are covered. *Coverage* includes:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications for all stages of mastectomy, including lymphedemas and at least two external postoperative prostheses subject to all of the terms and conditions of the *policy*.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).Statement of Non-Discrimination

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

Arizona Complete Health:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters

• Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages

If you need these services, contact Member Services at: Arizona Complete Health 1-888-926-5057 (TTY: 711).

If you believe that Arizona Complete Health 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 the Chief Compliance Officer, Cheyenne Ross. You can file a *grievance* in person, by mail, fax, or email. *Your grievance*

must be in writing and must be submitted within 180 days of the date that the person filing the *grievance* becomes aware of what is believed to be discrimination.

Submit *your grievance* to:

Arizona Complete Health Chief Compliance Officer-Cheyenne Ross

1870 W. Rio Salado Parkway, Tempe, AZ 85281. Fax: 1-877-615-7734

Email: AzCHMarketplace@AZCompleteHealth.com

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 at U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201; or by phone: 1-800-368-1019, 1-800-537-7697 (TTY).

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

arizona complete health

Attention: If you speak a language other than English, oral interpretation and written translation are available to you free of charge to understand the information provided. Call 1-866-918-4450 (TTY:TDD 711).

Spanish	Si habla español, dispone sin cargo alguno de interpretación oral y traducción escrita. Llame al 1-866-918-4450 (TTY:TDD 711).
Navajo	Diné k'ehjí yáníłti'go ata' hane' ná hóló̜ dóó naaltsoos t'áá Diné k'ehjí bee bik'e'ashchí̜í̜go nich'į' ádoolníiłgo bee haz'ą́ ałdó' áko díí t'áá át'é t'áá jíík'e kót'éego nich'į' ą́ą́'át'é. Kojį' hólne' 1-866-918-4450 (TTY:TDD 711).
Chinese (Mandarin)	若您讲中文，我们会免费为您提供口译和笔译服务。请致电 1-866-918-4450 (TTY:TDD 711) 。
Chinese (Cantonese)	我們為中文使用者免費提供口譯和筆譯。請致電 1-866-918-4450 (TTY:TDD 711)
Vietnamese	Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ thông dịch bằng lời và biên dịch văn bản miễn phí dành cho quý vị. Hãy gọi 1-866-918-4450 (TTY:TDD 711).
Arabic	إذك انت تتحدث اللغة العربية، تتوفر لك ترجمة شفهية وترجمة تحريرية مجانًا اتصل بالرق 1-866-918- 4450 (TTY:TDD 711).م
Tagalog	Kung ikaw ay nagsasalita ng Tagalog, mayroong libreng oral na interpretasyon at nakasulat na pagsasalin na maaari mong gamitin. Tumawag sa 1-866-918-4450 (TTY:TDD 711).
Korean	한국어를 하실 경우, 구두 통역 및 서면 번역 서비스를 무료로 제공해드릴 수 있습니다. 1-866-918-4450 (TTY:TDD 711)번으로 전화하십시오.
French	Si vous parlez français,vous disposez gratuitement d'une interprétation orale et d'une traduction écrite. Appelez le 1-866-918-4450 (TTY:TDD711)
German	Für alle, die Deutsch sprechen, stehen kostenlose Dolmetscher- und Übersetzungsservices zur Verfügung. Telefon: 1-866-918-4450 (TTY:TDD 711).
Russian	Если вы говорите по-русски, услуги устного и письменного перевода предоставляются вам бесплатно. Звоните по телефону 1-866-918-4450 (TTY:TDD 711).
Japanese	日本語を話される方は、通訳（口頭）および翻訳（筆記）を無料でご利用いただけます。 電話番号 1-866-918-4450 (TTY:TDD 711)
Persian (Farsi)	اگر به زباف انرسی صحبت میکنید, ترجمه شهافی و تکبی بدون هزینه برىا شما قابل دسترسی میباشد با شمار 1-866-918-4450 (TTY:TDD 711)T ه تماس بگـيريد.
Syriac	[illegible] 1-866-918-4450 (TTY:TDD 711)
Serbo-Croatian	Ako govorite srpsko hrvatski, usmeno i pismeno prevođenje vam je dostupno besplatno. Nazovite 1-866-918-4450 (TTY:TDD 711).
Thai	หากคุณพูดภาษา ไทย เรามีบริการล่ ามและแปลเอกสาร โดยไม่ มีค่ าใช้ จ่ าย โทรศัพท์ 1-866-918-4450 (TTY:TDD 711)