



FROM



2022 Evidence of Coverage



Ambetter.BuckeyeHealthPlan.com

Ambetter Individual Health Benefit Plan
Issued and underwritten by Buckeye Health Plan
Home Office: 4349 Easton Way, Suite 300, Columbus, OH, 43219

Individual Member Contract

In this *contract*, the terms “*you*,” “*your*,” or “*yours*” will refer to the *member* or any *dependents* enrolled in this *contract*. The terms “Ambetter,” “*we*,” “*our*,” or “*us*” will refer to Ambetter from Buckeye Health Plan.

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

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

From time to time, *we* will change the rate table used for this *contract* form. Each premium will be based on the rate table in effect on that premium's due date. The policy plan, and age of *members*, type and level of benefits, and place of *residence* on the premium due date are some of the factors used in determining *your* premium rates. *We* have the right to change premiums after filing and *approval* by the state.

At least 31 day 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 *contract* or a change in a *member's* health. While this *contract* is in force, *we* will not restrict coverage already in force.

Referrals are not required for *you* to access a *specialist provider* or *other practitioner* (not *your PCP*) care within the *network*. Referrals for out-of-*network* services must always be reviewed by the health plan for medical necessity determination and *in-network provider* availability for benefits to be payable under *your contract* or benefits payable under this *contract* will be denied. Out of *Network* services are not covered unless *prior authorization* is received

This *contract* is not a Medicare supplement *contract*. If *you* are eligible for Medicare, review the “Guide to Health Insurance for People with Medicare” available from the company.

COORDINATION OF BENEFITS

NOTICE: IF *YOU* OR *YOUR* FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTHCARE PLAN, *YOU* MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE *YOU* TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND *HOSPITALS*, AND IT MAY BE IMPOSSIBLE TO

COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY *OTHER PLAN* THAT COVERS *YOU* OR *YOUR* FAMILY.

TEN DAY RIGHT TO RETURN CONTRACT

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

Buckeye Health Plan

A handwritten signature in black ink, appearing to read 'S. Province', with a stylized, cursive script.

Steven B. Province, CEO and Plan President

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Introduction

Welcome to Ambetter from Buckeye Health Plan! *We* have prepared this *contract* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services. It describes:

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

This *contract*, with the application, amendments and *Schedule of Benefits*, attached shall constitute the entire *contract* under which *covered services* and supplies are provided or paid for by *us*.

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

How To Contact Us

Ambetter from Buckeye Health Plan
4349 Easton Way, Suite 300
Columbus, OH, 43219

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST, Monday through Friday
Member Services **1-877-687-1189**
TTY/TDD line **1-877-941-9236**
Fax **1-877-941-8076**
Emergency **911**
24/7 Nurse Advice Line **1-877-687-1189**

Interpreter Services

Ambetter from Buckeye Health Plan has a free service to help *our members* who speak languages other than English. These services ensure that *you* and *your provider* can talk about *your* medical or *behavioral health* concerns in a way that is most comfortable for *you*.

Our interpreter services are provided at no cost to *you*. *We* have representatives that speak Spanish and have medical interpreters to assist with languages other than English via phone. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation. To arrange for interpretation services, please call Member Services at 1-877-687-1189 or for the hearing impaired (TTY/TDD 1-877-941-9236).

Member Rights and Responsibilities

We are committed to:

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

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

You have the right to:

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

- b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
13. A current list of *network providers*. A listing of *network providers* is available online at Ambetter.BuckeyeHealthPlan.com. *You* can find any of *our network providers* by visiting *our* website and using the “Find a Provider” function. *You* can also get information on *your network providers’* education, training, and practice.
14. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
15. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, ethnicity, race, gender, sex, sexual orientation, disability, national origin, or religion.
16. Access *medically necessary emergency services* 24 hours a day and seven days a week.
17. Access *medically necessary* urgent care through *network providers* 24 hours a day and seven days a week, including *our* 24/7 Nurse Advice Line.
18. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
19. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *primary care provider’s* instructions are not followed. *You* should discuss all concerns about treatment with *your primary care provider*. *Your primary care provider* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
20. 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.
21. Know the name and job title of people giving *you* care. *You* also have the right to know which *provider* is *your primary care provider*.
22. An interpreter when *you* do not speak or understand the language of the area.
23. A second opinion by a *network provider*, if *you* want more information about *your* treatment or would like to explore additional treatment options.
24. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it.
25. Advance directives are forms *you* can complete to protect *your* rights for *medical care*. It can help *your primary care provider* and other *providers* understand *your* wishes about *your* health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for *yourself*. Examples of advance directives include:
 - a. Living Will;
 - b. Health Care Power of Attorney; or
 - c. “Do Not Resuscitate” Orders. *Members* also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this entire *contract*.
2. Treat all *healthcare professionals* and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of *your provider* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* ID card and keep scheduled appointments with *your provider*, and call the *provider’s* office during office hours whenever possible if *you* have a delay or cancellation.
6. Know the name of *your* assigned *primary care provider*. *You* should establish a relationship with *your provider*. *You* may change *your primary care provider* verbally or in writing by contacting Member Services.
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 *providers* 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 providers* 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 providers*.
11. Tell *your healthcare professional and physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with *your primary care provider* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies, and procedures.
13. Use any emergency room only when *you* think *you* have a medical emergency. For all other care, *you* should call *your primary care provider*.
14. When *you* enroll in this coverage, give all information about any other medical coverage *you* have. If, at any time, *you* get other medical coverage besides this coverage, *you* must tell the entity with which *you* enrolled.
15. Pay *your* monthly premium on time and pay all *deductible amounts, copayment amounts, or cost sharing percentages* at the time of service.
16. Inform the entity in which *you* enrolled for this *contract* if *you* have any changes to *your* name, address, or family members covered under this *contract* within 60 days from the date of the event.
17. Provide notification of any enrollment related changes that would affect *your policy*, such as: birth of a child or adoption, marriage, divorce, adding/removing a dependent, *spouse/domestic partner* becomes eligible under a different insurer, enrollment changes or incarceration where *member* cost share would need to transfer from one policy to another policy.

Continuity of Care

Under the No Surprises Act, if a *member* is receiving a *covered service* with respect to an *network provider* or *facility* and: (1) the contractual relationship with the *provider* or *facility* is terminated, such that the *provider* or *facility* is no longer in network; or (2) benefits are terminated because of a change in the terms of the participation of the *provider* or *facility*, as it pertains to the benefit the member is receiving, then *we* will: (1) notify each enrollee who is a *continuing care patient* on a timely basis of the termination and their right to elect continued transitional care from the *provider* or *facility*; (2) provide the individual with an opportunity to notify the health plan of the individual's need for transitional care; and (3) permit the individual to elect to continue to have their benefits for the course of treatment relating to the individual's status as a *continuing care patient* during the period beginning on the date on which the above notice is provided and ending on the earlier of (i) the 90-day period beginning on such date; or the (ii) date on which such individual is no longer a *continuing care patient* with respect to their *provider* or *facility*.

Important Information

Provider Directory

A listing of *network providers* is available online at Ambetter.BuckeyeHealthPlan.com. We have plan *providers*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* healthcare services. *You* can find *our network providers* by visiting *our* website and using the “Find a Provider” function. There *you* will have the ability to narrow *your* search by *provider* specialty, zip code, gender, languages spoken and whether or not they are currently accepting new patients and languages spoken. *Your* search will produce a list of *providers* based on *your* search criteria and will give *you* other information such as name, address, phone number, office hours, and qualifications, specialty and board certifications.

At any time, *you* can request a printed copy of the *provider* directory at no charge by calling Member Services at 1-877-687-1189 (TTY/TDD 1-877-941-9236). In order to obtain benefits, *you* must designate a *network primary care provider* for each *member*. We can help *you* pick a *primary care provider (PCP)*. We can make *your* choice of *primary care provider* effective on the next business day.

Call the *provider's* office if *you* want to make an appointment. If *you* need help, call Member Services at 1-877-687-1189 (TTY/TDD 1-877-941-9236). We will help *you* make the appointment.

Member ID Card

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

The ID card will show *your* name, *member* ID#, and any *copayment amounts* required at the time of service. If *you* do not get *your* ID card within a few weeks after *you* enroll, please call Member Services at 1-877-687-1189 (TTY/TDD 1-877-941-9236), twenty-four hours per day, seven days a week. We will send *you* another card.

Website

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

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

Quality Improvement

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

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

4. A Quality Improvement Committee which includes *network providers* to help *us* develop and monitor *our* program activities.
5. Investigating any *member* concerns regarding care received.

For example, if *you* have a concern about the care *you* received from *your network provider* or service provided by *us*, please contact Member Services at **1-877-687-1189 (TTY/TDD 1-877-941-9236)**.

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.

Protection from Balance Billing

Under No Surprises Act (a federal law), effective January 1, 2022, *non-network providers* or *facilities* are prohibited from *balance billing members* for:

1. *Emergency services* provided to a *member*, regardless of plan participation; or
2. Non-emergency health care services provided to a *member* at an *in-network hospital* or at a network ambulatory surgical facility if the *member* did not give informed consent or *prior authorization* to be seen by the *non-network provider* pursuant to the federal No Surprises Act.

Ohio's House Bill 388 and the Federal No Surprises Act establish patient protections including from out-of-network *providers'* surprise bills ("*balance billing*") for emergency care and other specified items or services. *We* will comply with these new state and federal requirements including how *we* process claims from certain out-of-network *providers*.

Definitions

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

Wherever used in this *contract*:

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

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

Adverse benefit determination means any of the following:

- a. *Adverse benefit determination* means a decision by a health plan issuer:
 1. To deny, reduce, or terminate a requested healthcare service or payment in whole or in part, including all of the following:
 - a. A determination that the healthcare service does not meet the health plan issuer's requirements for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness, including *experimental or investigational treatments*;
 - b. A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non-employer group, to participate in a plan or health insurance coverage;
 - c. A determination that a healthcare service is not a covered benefit;
 - d. The imposition of an exclusion, including an exclusion for pre-existing conditions, source of *injury, network*, or any other limitation on benefits that would otherwise be covered.
 2. Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-employer group;
 3. To rescind coverage on a health benefit plan.

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

Affordable Care Act "ACA" means the comprehensive healthcare reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "*Affordable Care Act*" is used to refer to the final, amended version of the law. This is often times referred to as Health Care Reform.

Air medical transportation means the transporting of a patient by rotorcraft air *ambulance* or fixed wing air *ambulance* with appropriately licensed and certified medical personnel.

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

Allowed amount (also see **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. This amount excludes agreed to amounts between the provider and us as a result of Federal or State Arbitration.

Please note, if you receive services from a non-network provider, you may be responsible for the difference between the amount the provider charges for the service (billed amount) and the allowed amount that we pay. This is known as balance billing. However, pursuant to the federal No Surprises Act, you will not be responsible for balance billing for out-of-network care that is otherwise covered under your plan and that is provided by a non-network provider at an in-network facility, unless you gave informed consent before receiving the services. You also will not be responsible for balance billing by a non-network provider or a non-network facility for emergency services or air ambulance services. See balance billing and non-network provider definitions for additional information. If you are balance billed in these situations, please contact Member Services immediately at the number listed on the back of your ID card.

Ambetter Telehealth means the preferred vendor who we have contracted with to provide telehealth services to members. Our preferred vendor contracts with providers to render telehealth services to members. These services can be accessed via <https://ambetter.buckeyehealthplan.com/health-plans/our-benefits/ambetter-telehealth.html>.

Ambulance means any motor vehicle that is specifically designed, constructed, or modified and equipped and is intended to be used to provide basic life support, intermediate life support, advanced life support, or mobile intensive care unit services and transportation upon the streets or highways of this state of persons who are seriously ill, injured, wounded, or otherwise incapacitated or helpless. Ambulance does not include air medical transportation or a vehicle designed and used solely for the transportation of non-stretcher-bound persons, whether hospitalized or handicapped or whether ambulatory or confined to a wheelchair.

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

Ambulette means a motor vehicle that is specifically designed, constructed, or modified and equipped and is intended to be used for transportation upon the streets or highways of this state of persons who require use of a wheelchair or other mobility aid.

Appeal means a request by the member or their authorized representative for the insurer to reconsider, reverse, or otherwise modify an adverse benefit determination.

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.

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

1. A person to whom you have given express, written consent to represent you 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 you;
3. A family member or a treating health care professional, but only when you are unable to provide consent.

Autism spectrum disorder refers to a group of complex disorders represented by repetitive and characteristic patterns of behavior and difficulties with social communication and interaction. The symptoms are present

from early childhood and affect daily functioning as defined by the most recent edition of the Diagnostic and Statistical manual of Mental Disorders or the International Classification of Diseases.

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

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

If *you* are *balance billed* contact Member Services immediately at the number listed on the back of *your* ID card.

Behavioral health includes both mental health and *substance use disorder*, encompassing a continuum of prevention, intervention, treatment and recovery support services.

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

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

Cardiac rehabilitation means to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning, and maintenance are not covered.

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

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of 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*.

Chemotherapy means the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.

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

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

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

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from *pregnancy*, but are adversely affected by *pregnancy* or are caused by *pregnancy* and not, from a medical viewpoint, associated with a normal *pregnancy*. This includes: ectopic *pregnancy*, spontaneous abortion, eclampsia, missed abortion, and similar medical and

surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, *provider* prescribed rest during the period of *pregnancy*, morning sickness, and conditions of comparable severity associated with management of a difficult *pregnancy*, and not constituting a medically classifiable distinct *complication of pregnancy*.

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

Continuing care patient means an individual who, with respect to a *provider* or facility, is (i) undergoing a treatment for a *serious and complex condition* from that *provider* or facility; (ii) is undergoing a course of institutional or inpatient care from that *provider* or facility; (iii) is scheduled to undergo non-elective *surgery* from that *provider*, including postoperative care; (iv) is pregnant and undergoing a course of treatment for the *pregnancy*; or (v) is determined to be *terminally ill* and is receiving treatment for such *illness*.

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

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

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

Cost sharing means the *deductible amount, copayment amount, and coinsurance* that *you* pay for *covered services*. The *cost sharing* amount that *you* are required to pay for each type of *covered service* is listed in the *Schedule of Benefits*. When *you* receive *covered services* from a *non-network provider* in a network facility, or when *you* receive *covered emergency services* or air *ambulance services* from *non-network providers*, *cost sharing* may be based on an amount different from the *allowed amount*.

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

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

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

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

1. Provided or incurred while the *member's* coverage is in force under this *contract*;
2. Covered by a specific benefit provision of this *contract*; and
3. Not excluded anywhere in this *contract*.

Covered vision services means vision care services or *vision care materials* for which a reimbursement is available under a *member's* health care *contract*, or for which a reimbursement would be available but for the application of contractual limitations such as a *deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, or any other limitation*.

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

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

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

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

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

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

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

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

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

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

Diagnostic services means tests or procedures performed when *you* have specific symptoms, to detect or monitor *your condition*.

1. X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
2. Magnetic Resonance Angiography (MRA).
3. Magnetic Resonance Imaging (MRI).
4. CAT scans.
5. Laboratory and pathology services.
6. Cardiographic, encephalographic, and radioisotope tests.
7. Nuclear cardiology imaging studies.
8. Ultrasound services.
9. Allergy tests.
10. Electrocardiograms (EKG).
11. Electromyograms (EMG) except that surface EMG's are not *covered services*.
12. Echocardiograms.
13. Bone density studies.
14. Positron emission tomography (PET scanning).
15. Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
16. Echographies.
17. Doppler studies.
18. Brainstem evoked potentials (BAER).
19. Somatosensory evoked potentials (SSEP).
20. Visual evoked potentials (VEP).
21. Nerve conduction studies.

22. Muscle testing.
23. Electrocardiograms.
24. Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a *hospital* or *provider's* office.

Dialysis treatments means treatment of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

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

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

Effective date means the date a *member* becomes covered under this *contract* for *illness* or *injury*.

Eligible cancer clinical trial means a cancer clinical trial that meets all of the following criteria:

1. A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
2. The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
3. The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
4. The trial does one of the following:
 - a. Tests how to administer a healthcare service, item, or drug for the treatment of cancer;
 - b. Tests responses to a healthcare service, item, or drug for the treatment of cancer;
 - c. Compares the effectiveness of a healthcare service, item, or drug for the treatment of cancer with that of other healthcare services, items, or drugs for the treatment of cancer; or
 - d. Studies new uses of a healthcare service, item, or drug for the treatment of cancer.
5. The trial is approved by one of the following entities:
 - a. The National Institutes of Health or one of its cooperative groups or centers under the United States Department of Health and Human Services;
 - b. The United States Food and Drug Administration;
 - c. The United States Department of Defense; or
 - d. The United States Department of Veterans' Affairs.
6. A medical professional has determined the cancer clinical trial is appropriate for the *member*.

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 stepchild;
4. A child placed with *you* for adoption; or
5. 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 Health Insurance Marketplace or *us*) if *your* child ceases to be an *eligible child*. *You* must reimburse *us* for any benefits that *we* provide or pay for a child at a time when the child did not qualify as an *eligible child*.

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

1. For *network providers*: When a *covered service* is received from a *network provider*, the *eligible service expense* is the contracted fee with that *provider*.
2. For *non-network providers*, unless otherwise required by Federal or Ohio state law, the *eligible service expense* is as follows:
 - a. When a covered *emergency service* is received from a *non-network provider*, the *eligible service expense* is the negotiated fee that has been agreed upon by *us* and the *provider*. If the *provider* has not agreed to a negotiated fee, the *eligible service expense* will be determined based on the greatest of the following:
 - i. the contracted amount *we* pay to *network providers* for the *covered service* in the same geographic area. If there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts;
 - ii. 100% of the fee Medicare allows for the same or similar services provided in the same geographical area; or
 - iii. the amount for the service calculated using the same method *we* generally use to determine payments for *non-network* health care services

If *you* are *balance billed* in these situations, please contact Member Services immediately at the number listed on the back of *your* ID card.

- b. When a *covered air ambulance service* is received from a *non-network provider*, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the *provider* as payment in full. If the *provider* has not agreed to accept a negotiated fee with *us* as payment in full, unless otherwise required by applicable law, the *eligible service expense* is reimbursement as determined by *us* and as required by applicable law. *You* will not be *balance billed* for the difference between the amount *we* pay and the *provider's* charges, but *you* may be subject to *cost sharing* obligations. If *you* are *balance billed* in these situations, please contact Member Services immediately at the number listed on the back of *your* ID card.
- c. When a *covered service* is received from a *non-network professional provider* who renders non-emergency services at an *in-network facility*, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the *provider* as payment in full. If the *provider* has not agreed to accept a negotiated fee with *us* as payment in full, unless otherwise required by applicable law, the *eligible service expense* will be determined based on the greatest of the following:
 - i. the contracted amount *we* pay to *network providers* for the *covered service* in the same geographic area. If there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts;
 - ii. 100% of the fee Medicare allows for the same or similar services provided in the same geographical area; or
 - iii. the amount for the service calculated using the same method *we* generally use to determine payments for *non-network* health care services.

Unless *you* receive and sign the necessary written notice and consent document under state law before the services are provided, *you* will not be *balance billed* for the difference between the amount *we* pay and the *provider's* charges, but *you* may be subject to *cost sharing* obligations. If *you* are *balance billed* in these situations, please contact Member Services immediately at the number listed on the back of *your* ID card.

- d. When a *covered service* is received from a *non-network provider* because the service or supply is not available from any *network provider* in *your service area* and is not the result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that the *provider* has agreed to accept as payment in full (*you* will not be billed for the difference between the negotiated fee and the *provider's* charge). If there is no negotiated fee agreed to by the *provider* with *us*, the *eligible service expense* is the greatest of the following (1) the amount that would be paid under Medicare; (2) the amount for the *covered service* calculated using the same method *we* generally use to determine payments for *non-network providers*; or (3) the contracted amount paid to *network providers* for the *covered service*. If there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts. *You* will

- not be balance billed by the *provider*, if you are, please contact Member Services.
- e. For all other *covered services* received from a *non-network provider* for which any needed *authorization* is received from us, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the *provider* as payment in full (you will not be billed for the difference between the negotiated fee and the *provider's* charge). If there is no negotiated fee agreed to by the *provider* with us, the *eligible service expense* is the greatest of the following: (i) the amount that would be paid under Medicare; (ii) the amount for the *covered service* calculated using the same method we generally use to determine payments for *non-network providers*; or (iii) the contracted amount paid to *network providers* for the *covered service* (if there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts). In addition to applicable *cost sharing*, you may be *balance billed* for these services.

Emergency medical condition means a medical condition manifesting itself by such acute symptoms of sufficient severity (including severe pain) that a prudent layperson with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

Emergency services means the following: (a) A medical screening examination, as required by federal law, that is within the capability of the emergency department of a *hospital*, including ancillary services routinely available to the emergency department, to evaluate an *emergency medical condition*; and b) Such further medical examination and treatment that are required by federal law to *stabilize* an *emergency medical condition* and are within the capabilities of the staff and facilities available at the *hospital*, including any trauma and burn center of the *hospital*. In addition, *emergency services* must be available on a seven-days-per-week, twenty-four hours-per-day basis in order to prevent jeopardy to a *member's* health status that would occur if such services were not received as soon as possible, and includes, where appropriate, provisions for transportation and indemnity payments or service agreements for out-of-area coverage.

Services you receive from a *non-network provider* or *non-network facility* after the point your emergency medical/behavioral health condition is *stabilized* continue to meet the definition of *emergency services* until (1) you are discharged from the facility, or (2) both of the following circumstances are met, as well as any other criteria required by federal or state law: (a) the *provider* or facility determines you are able to travel using nonmedical transportation or nonemergency medical transportation, and (b) your *provider* obtains informed consent to provide the additional services.

Essential health benefits provided within this Certificate 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. *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.

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

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*USFDA*) regulation, regardless of whether the trial is subject to *USFDA* oversight.
2. An *unproven service*.
3. Subject to *USFDA* approval, and:
 - a. It does not have *USFDA* approval;

- b. It has *USFDA* approval only under its Treatment *Investigational* New Drug regulation or a similar regulation; or
 - c. It has *USFDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *USFDA*-approved drug is a use that is determined by us to be:
 - i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
 - ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
 - iii. Not an *unproven service*; or
 - d. It has *USFDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *USFDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member*.
4. *Experimental* or *investigational* according to the *provider's* research protocols.

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.

External review means a review by an external *third party*, and *Independent Review Organization (IRO)* which is binding, except to the extent that the health plan issuer has other remedies available under applicable state law.

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

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

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

Grievance (Complaint) means any *complaint* or dispute expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Health Insurance Marketplace health plan, or its *providers*, regardless of whether remedial action is requested.

Habilitation means *medically necessary* habilitative services and devices which are health care services and devices 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 for people with disabilities in a variety of inpatient and/or outpatient settings.

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

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

Healthcare provider or **provider** means a *healthcare professional* or facility.

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

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

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

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

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

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

Hospice refers to services designed for and provided to *Members* who are not expected to live for more than 6 months, as certified by an Ambetter *physician*. Ambetter works with certified *Hospice* programs licensed by the state to minimize patient discomfort and address the special physical, psychological, and social needs of *Terminally Ill Members* and their *Immediate Family*.

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 *contract*.

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

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

Independent review organization (IRO) means an entity that is accredited by a nationally recognized private accrediting organization to conduct independent *external reviews of adverse benefit determinations* and by the superintendent of insurance in accordance with Ohio law.

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

Inhalation therapy means the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. *Covered services* include but are not limited to, introduction of dry or moist gases into the lungs; non-pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

In-network means services provided by a *network provider* (or *preferred provider*).

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

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

1. Charges from a *hospital*, *skilled nursing facility* (SNF) or other *provider* for room, board and general nursing services.
2. Ancillary (related) services.
3. Professional services from a *provider* while an inpatient.

Room, Board, and General Nursing Services include:

1. A room with two or more beds.
2. A private room. The private room allowance is the *hospital's* average semi-private room rate unless it is *medically necessary* that *you* use a private room for isolation and no isolation facilities are available.
3. A room in a special care unit approved by *us*. The unit must have facilities, equipment, and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services include:

1. Operating, delivery and treatment rooms and equipment.
2. Prescribed drugs.
3. Anesthesia, anesthesia supplies and services given by an employee of the *hospital* or other *provider*.
4. Medical and surgical dressings, supplies, casts, and splints.
5. *Diagnostic services*.
6. Therapy services.

Professional Services include:

1. *Medical care* visits limited to one visit per day by any one *physician*.
2. Intensive *medical care* for constant attendance and treatment when *your* condition requires it for a prolonged time.
3. Concurrent care for a medical condition by a *physician* who is not *your* surgeon while *you* are in the *hospital* for surgery. Care by two or more *physicians* during one *hospital* stay when the nature or severity of *your* condition requires the skills of separate *physicians*.
4. Consultation which is a personal bedside examination by another *physician* when requested by *your physician*. Staff consultations required by *hospital* rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.

5. *Surgery* and the administration of general anesthesia.
6. Newborn exam. A *physician* other than the *physician* who performed the obstetrical delivery must do the examination.

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

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

Licensed mental health professional means a professional that holds a clinical license in a *behavioral health* discipline; and possesses the training or experience to complete the required evaluation and treatment of *behavioral health* disorders.

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

Loss of minimum essential coverage means in the case of an employee or *dependent* who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of *loss* of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage).

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

Manipulation therapy includes osteopathic/chiropractic *manipulation therapy* used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for *manipulation therapy* services as specified in the *Schedule of Benefits*. *Manipulation therapy* services rendered in the home as part of *home care services* are not covered.

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

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

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

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

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

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

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

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

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

Medically necessary means *our* decision as to whether any medical service, supply, item, or treatment to diagnose and treat a *member's illness* or *injury*:

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

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

Medically necessary medical supplies mean medical supplies that are:

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

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

Medically stabilized for non-emergency services means that the person is no longer experiencing further deterioration as a result of a prior *injury* or *illness* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute *medical care*. Acute *medical care* does not include *acute rehabilitation*. With respect to an *emergency medical condition*, please see the definition, *stabilize*.

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

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

Minimum essential coverage (MEC) means any insurance plan that meets the *Affordable Care Act* requirement for having health coverage. Examples of plans that qualify include: Health Insurance Marketplace plans, job-based plans (including COBRA coverage), Medicare, and Medicaid and CHIP.

Network means a group of providers or facilities (including, but not limited to hospitals, inpatient mental healthcare facilities, medical clinics, *behavioral health* clinics, acupuncturists, chiropractors, massage therapists, nurse practitioners, addiction medicine practitioners, etc.) who have contracts with *us*, or *our* contractor or subcontractor, and have agreed to provide healthcare services to *our members* for an agreed upon fee. *Members* will receive most if not all of their healthcare services by accessing the *network*.

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

Network provider (or preferred provider) means any person or entity that has entered into a contract with Ambetter from Buckeye Health Plan 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*.

Non-elective caesarean section means:

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

Non-network eligible service expense means the *eligible service expense* for services or supplies that are provided and billed by a *non-network provider*.

Non-network provider (or non-preferred provider) means a *physician*, *provider*, *provider facility*, or other *provider* who is NOT identified in the most current list for the *network* shown on *your* identification card. Services received from a *non-network provider* are “out-of-network” and are not covered, except for:

1. *Emergency services*, as described in the Medical Service and Supply Benefits section of this *contract*;
2. Non-emergency healthcare services received at an *in-network* facility, as described in the Access to Care section of this *contract*; or
3. Situations otherwise specifically described in this *contract*.

Occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person’s ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person’s particular occupational role. *Occupational therapy* does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-covered services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation, and other types of similar equipment.

Oral chemotherapy means the treatment with drugs given by mouth to kill cancer cells or stop them from dividing.

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

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

Other practitioner means as used in *your Schedule of Benefits* and related to mental health/*substance use disorder* services, refers to a mental health or *substance use disorder provider* licensed/certified by the state in which care is being rendered and performing services within the scope of that license/certification.

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

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

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

Physical therapy including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neurophysiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following *illness*, *injury*, or loss of a body part. Non-covered services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or *illness*; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.

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

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

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

Predetermination means a written request by the *member* to determine if a proposed treatment or service by the *member's PCP* or *provider* is covered under the *contract*. This process is voluntary and the *predetermination* is dependent upon complete and accurate information submitted before the services are rendered. Payment is dependent upon the information submitted after the services are rendered.

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

Prescription drug means any medicinal substance whose label is required to bear the legend "RX only." This also includes over-the-counter drugs prescribed by a *provider*.

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

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

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

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

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

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

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

Pulmonary rehabilitation means to restore an individual's functional status after an *illness* or *injury*. *Covered services* include but are not limited to outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is *inhalation therapy* administered in *physician's* office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. *Pulmonary rehabilitation* in the acute inpatient *rehabilitation* setting is not a *covered service*.

Qualified health plan or **QHP** means a health plan that has in effect a certification that it meets the standards issued or recognized by each Health Insurance Marketplace through which such plan is offered.

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

Radiation therapy means the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.

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

Rehabilitation means care for restoration (including by education or training) of one's prior ability to function at a level of *maximum therapeutic benefit*. This includes *acute rehabilitation*, *sub-acute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy* and *pain management programs*.

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

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

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

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

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

Rescission of a policy, which differs from the term in General Provisions, means a cancellation or discontinuance of coverage that has a retroactive effect. *Rescission* does not include a cancellation or discontinuance or coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

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

Residential treatment facility means a facility, including those for treatment of mental health and *substance use disorders*, that provides (with or without charge) sleeping accommodations, and:

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

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

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

Serious and complex condition means, in the case of an acute *illness*, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or, in the case of a chronic *illness* or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized *medical care* over a prolonged period of time.

Service area means a geographical area, made up of counties, where *we* have been *authorized* by the State of Ohio to sell and market *our* health plans. This is where the majority of *our* participating *providers* are located where *you* will receive all of *your* healthcare services and supplies. *You* can receive precise *service area* boundaries from *our* website or Member Services.

Skilled nursing facility means a *provider* constituted, licensed, and operated as set forth in applicable state law, which:

1. mainly provides inpatient care and treatment for persons who are recovering from an *illness* or *injury*;
2. provides care supervised by a *physician*;
3. provides 24 hour per day nursing care supervised by a full-time registered nurse;
4. is not a place primarily for care of the aged, custodial or domiciliary care, or treatment of alcohol or drug dependency; and
5. is not a rest, educational, or custodial *provider* or similar place.

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

Specialist provider is a *physician* or *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.

Speech therapy for the correction of a speech impairment.

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

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

1. Placing the health of the individual or, with respect to a pregnant person, the health of the person or the unborn child, in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part; or
4. In the case of a person having contractions, *stabilize* means such medical treatment as may be necessary to deliver, including the placenta.

Sub-acute rehabilitation means one or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for one-half hour to two hours per day, five to seven days per week, while the *covered person* is confined as an inpatient in a *hospital*, *rehabilitation facility*, or *extended care facility*.

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

Surgery or **surgical procedure** means:

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

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.

Surrogate pregnancy means a *surrogate pregnancy* is one in which a woman has agreed to become pregnant with the intention of surrendering custody of the child to another person.

Surveillance tests for ovarian cancer means annual screening using:

1. CA-125 serum tumor marker testing;
2. Transvaginal ultrasound; or

3. Pelvic examination.

Telehealth services means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, *care management*, and self-management of a patient's health care while the patient is at the originating site and the *provider* for *Telehealth* is at a distant site. *Telehealth services* include synchronous interactions and asynchronous store and forward transfers. Store and forward transfers is a process, such as that used by email that allows data to be stored until it can be sent if there is no connection available immediately. *Virtual Care and Telehealth services* are one in the same. *Ambetter's Telehealth services* are known as "Virtual Care from Ambetter Telehealth" "for marketing purposes. This coverage is provided on the same basis and to the same extent (included cost shares) for the provision of in-person health care services.

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

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

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

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

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

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

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

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

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

Urgent care service means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay, but that does not pose a threat to the life, limb, or permanent health of the injured or ill person, and may include such health care services provided out of *our* approved *service area* pursuant to indemnity payments or service agreements.

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

Vision care materials includes lenses, devices containing lenses, prisms, lens treatments and coatings, contact lenses, orthotics, vision training, and any *prosthetic device* necessary to correct, relieve, or treat any defect or abnormal condition of the human eye or its adnexa.

You means a policyholder, subscriber, enrollee, *member*, or individual covered by a health benefit plan. *You* does include *your authorized representative* with regard to an internal *appeal* or *external review* in accordance with the Appeals and Grievance Procedures section. *You* does not include *your* representative in any other context.

Dependent Member Coverage

Dependent Member Eligibility

Your dependent members become eligible for coverage under this contract on the latter of:

1. The date you became covered under this contract; or
2. The date of an eligible newborn's birth; or
3. The first day of the premium period/first full calendar month after the date of becoming your dependent.

Effective Date for Initial Dependent Members

The effective date for your initial dependent members will be the same date as your initial coverage date. Only dependent members included in the application for this contract will be covered on your effective date.

Adding a Newborn Child

An eligible child born to you or a family member will be covered from the time of birth until the 31st day after its birth. Each type of covered service incurred by the newborn child will be subject to the cost sharing amount listed in the Schedule of Benefits.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth. If notice of the newborn is given to us by the Health Insurance Marketplace within the 31 days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 days after the birth of the child. If notice is given by the Health Insurance Marketplace within 60 days of the birth of the child, the contract may not deny coverage of the child due to failure to notify us of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st day after its birth, unless we have received notice from the entity that you enrolled (either the Health Insurance Marketplace or us).

Adding an Adopted Child

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

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

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

As used in this provision, "placement" is the assumption and retention by you or your spouse for total or partial support of the child in anticipation of the adoption of the child.

Adding Other Dependent Members

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

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 services* after the *effective date*, *your* Ambetter coverage will apply for covered benefits related to the *Inpatient services* after *your effective date*. Ambetter coverage requires *you* to notify Ambetter within 2 days of *your* effective date or as soon as reasonably possible so *we* can review and authorize *medically necessary* services. If services are at a non-contracted *hospital*, claims will be paid at the *allowed amount* and *you* may be billed for any balance of costs above the *allowed amount*.

Ongoing Eligibility

For All Covered Persons

A *member's* eligibility for coverage under this *contract* will cease on 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*;
2. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact;
3. The date *we* decline to renew this *contract*, as stated in the Discontinuance provision under the Termination section;
4. The date of termination that the Health Insurance Marketplace provides *us* upon *your* request of cancellation to the Health Insurance Marketplace, or if *you* enrolled directly with *us*, the date *we* receive a request from *you* to terminate this *contract*, or any later date stated in *your* request; or
5. The *member's* death.

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

For Dependent Members

A *dependent member* will cease to be a *member* at the end of the premium period in which he or she ceases to be *your dependent member* due to divorce or if a child ceases to be an *eligible child*. For *eligible children*, the coverage will terminate the thirty-first of December the year the *dependent* turns 26 years of age.

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

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

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

Proof of incapacity and dependence shall be furnished to *us* within thirty-one days of the child's attainment of the limiting age. Upon request, but not more frequently than annually, *we* may require proof satisfactory to *us* of the continuance of such incapacity and dependency.

Out of Service Area Dependent Member Coverage

A *dependent member's* coverage will not cease should the *dependent member* live outside the *service area* if a court order requires the *member* to cover such *dependent member*.

Open Enrollment

Each year there will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 1, 2021 and extends through January 15, 2022. *Qualified individuals* who enroll on or before December 15, 2021 will have an *effective date* of coverage on January 1, 2022.

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

1. The *qualified individual* has not been determined eligible for *advanced premium tax 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. We will send written annual open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

Special Enrollment

In general, a qualified individual has 60 days to report certain life changes, known as “qualifying events” to the Health Insurance Marketplace or by using Ambetter’s *Enhanced Direct Enrollment* tool. *Qualified Individuals* may be granted a Special Enrollment Period where they may enroll in or change to a different Marketplace plan during the current plan year if they have a qualifying event. Qualifying events include:

1. A *qualified individual* or *dependent* loses *minimum essential coverage*, non-calendar year group or individual health insurance coverage, *pregnancy-related coverage*, access to healthcare services through coverage provided to a pregnant enrollee’s unborn child, or medically needed coverage;
2. A *qualified individual* gains a *dependent* or becomes a *dependent* through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order. In the case of marriage, at least one *spouse* must demonstrate having *minimum essential coverage* as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage;
3. A *qualified individual* or *dependent*, who was not previously a citizen, national, or lawfully present individual gains such status; or who is no longer incarcerated or whose incarceration is pending the disposition of charges;
4. A *qualified individual*’s enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or its instrumentalities as evaluated and are determined by the Health Insurance Marketplace;
5. An enrollee or *dependent* adequately demonstrates to the Health Insurance Marketplace that the plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
6. A *qualified individual*, enrollee, or *dependent*, adequately demonstrates to the Health Insurance Marketplace that a material error related to plan benefits, *service area*, or premium influenced the qualified individual’s or enrollee’s decision to purchase the *QHP*;
7. An enrollee or *dependent* enrolled in the same plan is determined newly eligible or newly ineligible for *advanced premium tax credits* or has a change in eligibility for *cost sharing reductions*;
8. A *qualified individual* or *dependent* who is enrolled in an eligible employer-sponsored plan is determined newly eligible for *advanced premium tax credits* based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-2(c)(3);
9. A *qualified individual*, enrollee, or *dependent* gains access to new *QHPs* as a result of a permanent move, and had *minimum essential coverage* as described in 26 CFR 1.5000A-1(b) for one or more days during the sixty days preceding the date of the permanent move;
10. A *qualified individual* or *dependent* who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a plan or change from one plan to another one time per month;
11. A *qualified individual* or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide;
12. A *qualified individual*, enrollee, or *dependent* is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B-2, and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
13. A *qualified individual* or *dependent* is determined to be potentially eligible for Medicaid or Children’s Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 days after the qualifying event; or applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;
14. A *qualified individual* newly gains access to an employer sponsored Individual Coverage Health Reimbursement Arrangement (ICHRA) (as defined in 45 CFR 146.123(b)) or a Qualified Small Employer

Health Reimbursement Arrangement (QSHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code);

15. At the option of the Health Insurance Marketplace, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a plan through the Health Insurance Marketplace following termination of enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence; or
16. A *qualified individual* or *dependent* is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions or government subsidies completely cease.

To determine if *you* are eligible and apply for a Special Enrollment Period, please visit [Healthcare.gov](https://www.healthcare.gov) and search for “special enrollment period.” The Health Insurance Marketplace is responsible for all healthcare eligibility and enrollment decisions for *members* who enrolled via the Marketplace.

If *you* are currently enrolled in Ambetter from Buckeye Health Plan, please contact Member Services at 1-877-687-1180 with any questions related to *your* health insurance coverage.

Coverage Effective Dates for Special Enrollment Periods

Regular effective dates. Except as specified below, coverage will be effective on the first of the month following plan selection.

Special effective dates. In the case of birth, adoption, placement for adoption, or placement in foster care, coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, or placement in foster care. In the case of marriage, or in the case where a qualified individual loses *minimum essential coverage*, coverage is effective on the first day of the following month.

In the case of erroneous enrollment, contract violation, or exceptional circumstances, coverage is effective on an appropriate date based on the circumstances of the special enrollment period, in accordance with guidelines issued by the Department of Health and Human Services. Such date must be either (i) the date of the event that triggered the special enrollment period or (ii) in accordance with the regular effective dates.

If a *qualified individual*, enrollee, or dependent loses coverage, gains access to a new *QHP*, becomes newly eligible for enrollment in a *QHP*, becomes newly eligible for advance payments of the premium tax credit in conjunction with a permanent move, or is enrolled in COBRA continuation coverage and employer contributions to or government subsidies completely cease, and if the plan selection is made on or before the day of the triggering event the Health Insurance Marketplace must ensure that the coverage effective date is the first day of the month following the date of the triggering event. If the plan selection is made after the date of the triggering event, coverage is effective on the first day of the following month.

If a *qualified individual*, enrollee, or *dependent* newly gains access to an ICHRA or is newly provided a QSEHRA, and if the plan selection is made before the day of the triggering event, coverage is effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If the plan selection is made on or after the day of the triggering event, coverage is effective on the first day of the month following plan selection.

If a *qualified individual*, enrollee, or *dependent* did not receive timely notice of an event that triggers eligibility for a special enrollment period, and otherwise was reasonably unaware that a qualifying event occurred, the Health Insurance Marketplace must allow the *qualified individual*, enrollee, or dependent to select a new plan within sixty days of the date that he or she knew, or reasonably should have known, of the occurrence of the triggering event. And at the option of a *qualified individual*, enrollee or dependent,

the Health Insurance Marketplace must provide the earliest effective that would have been available, based on the applicable qualifying event.

Loss of Minimum Essential Coverage

Loss of Minimum Essential Coverage does not include a *loss* due to the failure of the employee or *dependent* to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). *Loss of eligibility for coverage* includes, but is not limited to:

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

Premiums

Premium Payment

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

Grace Period

When a *member* is receiving a premium subsidy:

After the first premium is paid, a grace period of 90 days 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 *advanced premium tax credits* are received.

We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period, and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. *We* will notify HHS of the non-payment of premiums, the *member*, as well as *providers*, of the possibility of denied claims when the *member* is in the second and third month of the grace period. *We* will continue to collect *advanced premium tax credits* on behalf of the *member* from the Department of the Treasury, and will return the *advanced premium tax credits* on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above.

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* and *dependents* during the grace period. *We* will notify HHS, as necessary, of the non-payment of premiums, the *member*, as well as *providers*, of the possibility of denied claims when the *member* is in the grace period.

Third Party Payment of Premiums or Cost Sharing

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

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

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

Similarly, if we determine payment was made for *Deductibles* or *Cost Sharing* by a *third party*, such as a drug manufacturer paying for all or part of a medication, that shall be considered a *third party* premium payment that may not be counted towards *your deductible* or *Maximum Out-of-Pocket* costs.

Misstatement of Age

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

Change or Misstatement of Residence

If you change your residence, you must notify us of your new residence or log into your Ambetter member portal to process your change via Ambetter's *Enhanced Direct Enrollment* tool, within sixty (60) days of the change. Your premium will be based on your new residence beginning on the first premium due date/first day of the next calendar month after the change. If your residence is misstated on your application, or you fail to notify us of a change of residence, we will apply the correct premium amount beginning on the first premium due date/first day of the first full calendar month you resided at that place of residence. If the change results in a lower premium, we will refund any excess premium. If the change results in a higher premium, you will owe us the additional premium.

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 contract, we have the right to rerate the contract back to the original effective date.

Billing/Administrative Fees

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

Cost Sharing Features

Cost Sharing Features

We will pay benefits for *covered services* as described in the *Schedule of Benefits* and the Medical Service and Supply Benefits section 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 *deductible*, *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 healthcare facility or *provider* to treat a condition or an *illness*. Each claim that we receive for services covered under this *contract* are adjudicated or processed as we receive them. Coverage is only provided for *eligible service expenses*. Each claim received will be processed separately according to the cost share as outlined in the *contract* and in your *Schedule of Benefits*.

Copayments

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

Coinsurance

A coinsurance amount is the percentage 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*.

Deductible

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

Maximum Out-of-Pocket

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

Refer to your Schedule of Benefits for Coinsurance Percentage and other limitations.

The amount provided or payable will be subject to:

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

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

Note: The bill you receive for services or supplies from a *non-network provider* may be significantly higher than the eligible service expenses for those services or supplies. In addition to the *deductible amount*, copayment

amount, and cost *sharing* percentage, *you* may be responsible for the difference between the *eligible service expense* and the amount the *non-network provider* bills *you* for the services or supplies (unless receiving emergency care or if use of a *non-network provider* was *authorized* by *us*). Any amount *you* are obligated to pay to the *non-network provider* in excess of the *eligible service expense* will not apply to *your deductible amount* or *maximum out-of-pocket*.

Access to Care

Primary Care Provider

In order to obtain benefits, *you* must designate a *network primary care provider* for each *member*. If *you* do not select a *network primary care provider* for each *member*, one will be assigned. *You* may select any *network primary care provider* who is accepting new patients. From any of the following *provider* types:

- Family practitioners
- General practitioners
- Internal medicine
- Nurse practitioners*
- Physician assistants
- Obstetricians/gynecologists
- Pediatricians (for children)

*If *you* choose a nurse practitioner as *your PCP*, *your* benefit coverage and *copayment amounts* are the same as they would be for services from other *in-network providers*. See *your* Summary of Benefits for more information.

However, *you* may not change *your* selection more frequently than once a month. If *you* do not select a *network primary care provider* for each *member*, one will be assigned. *You* may obtain a list of *network primary care providers* at *our* website and using the "Find a Provider" function or by calling the telephone number shown on the front page of this *contract*.

You should get to know *your PCP* and establish a healthy relationship with them. *Your PCP* will:

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

Your network primary care provider will be responsible for coordinating all covered health services with other *network providers*. *You* may be required to obtain a referral from a *primary care provider* in order to receive care from a *specialist provider*. *You* do not need a referral from *your network primary care provider* for mental or behavioral health services, obstetrical or gynecological treatment and may seek care directly from a *network obstetrician or gynecologist*.

Contacting Your Primary Care Physician

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

Should *you* need care outside of *your PCP's* office hours, *you* should call *your PCP's* office for information on receiving after hours care in *your* area. If *you* have an urgent medical problem or question or cannot reach *your PCP* during normal office hours, call *our* 24/7 Nurse Advice line at 1-877-687-1189 (TTY/TDD 1-877-941-9236). A licensed nurse is always available and ready to answer *your* health questions. In an emergency, call 911 or head straight to the nearest emergency room.

Changing Your Primary Care Physician (PCP)

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

Requests for Predeterminations of Benefits

You may request a *predetermination* of coverage. Any *predetermination* *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the *predetermination*:

1. The *predetermination* was based on incomplete or inaccurate information initially received by *us*.
2. The medical expense has already been paid by someone else.

We will make a determination within two business days after obtaining all necessary information regarding a proposed service. *We* will notify the *provider* by phone or facsimile within three business days of *our* decision. If *we* denied the *predetermination*, *we* will provide written or electronic confirmation within one business day of the telephone notification to *you* and the *provider*. If *you* disagree with *our* decision, *you* may *appeal* pursuant to the Appeals and Grievance Procedures section.

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

If *we* *authorize* a proposed admission, treatment, or *covered service expense* by a *network provider* based upon the complete and accurate submission of all necessary information relative to an eligible *member*, *we* shall not retroactively deny this *authorization* if the *network provider* renders the *covered service expense* in good faith and pursuant to the *authorization* and all of the terms and conditions of the *network provider's contract* with *us*.

Service Area

Ambetter from Buckeye Health Plan operates in a limited *service area*. If the subscriber moves from one county to another within the *service area*, the monthly premiums may be increased or changed. If the subscriber moves from one county in the *service area* to another that is not in the *service area*, *you* will no longer be eligible for coverage under this *contract*, and will be eligible for special enrollment into another *qualified health plan*.

Coverage Under Other Policy Provisions

Charges for services and supplies that qualify as *covered service expenses* under one benefit provision will not qualify as *covered service expenses* under any other benefit provision of this *contract*.

Emergency Services

If *you* are experiencing an emergency, call 9-1-1 or go to the nearest *hospital*. *Emergency services* do not require *prior authorization*. If those services provided are utilized at a *non-network hospital*, and a *member* presents with an *emergency medical condition* under one of the following circumstances, emergency care will be covered under 2(a) of the *eligible service expense* definition:

- a) Due to circumstances beyond the *member's* control, the *member* was unable to utilize a *network hospital's* emergency department without serious threat to life or health;
- b) A prudent layperson with an average knowledge of health and medicine would have reasonably believed that, under the circumstances, the time required to travel to a *network hospital's* emergency department could result in one or more of the adverse health consequence;
- c) A person *authorized by us* refers the *member* to an emergency department and does not specify a *network hospital's* emergency department;
- d) An *ambulance* takes the *member* to a *non-network hospital* other than at the direction of the *member*;
- e) The *member* is unconscious;
- f) A natural disaster precluded the use of a *network hospital's* emergency department; or
- g) The status of a *hospital* changed from *network* to *non-network hospital* with respect to *emergency*

services during a *contract* year and no good faith effort was made by *us* to inform *members* of this change.

Should the *emergency service* visit at a *non-network hospital* fall outside the above circumstances, the *eligible service expense* would be covered under (2) (b) of the *eligible service expense* definition. *You* may be subject to balance billing from the *non-network provider*.

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

Non-Emergency Services

If *you* are traveling outside of the *Ohio 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 Ohio by searching the relevant state in *our provider* directory at <https://guide.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.

Non-Network Providers at Hospitals or Ambulatory Surgical Facilities

A *non-network provider* cannot *balance bill* *you* for services provided at a *network hospital*, or for surgical or ancillary services provided at a network ambulatory surgical facility unless *your provider* has furnished a required notice under the No Surprises Act and *you* have given consent. If *you* are treated by a *non-network provider* at a *network hospital* or ambulatory surgical facility, *your cost sharing* responsibility for the non-network services will be no greater than if the *provider* had been in *our* network.

You may not be *balance billed* for non-emergency ancillary services (emergency medicine, anesthesiology, pathology, radiology, and neonatology, as well as *diagnostic services* (including radiology and laboratory services)) received from a *non-network provider* at a *network hospital* or *network* ambulatory facility.

Emergency Services Outside of Service Area

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

New Technology

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

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

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

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

As innovative technologies and solutions are established in market under expedited research and development, *we* may elect to offer, at *our* discretion, new services or preferred partnerships designed to improve access to care and enhance *care management*. Ambetter will provide access to *third party* services at preferred or

discounted rate. The preferred or discounted rates to these services may be communicated to all *members* by email, mail or phone promotions. The preferred partnerships are optional benefits to all *members*.

Medical Service and Supply Benefits

The Plan provides coverage for healthcare services for a *member* and/or *dependents*. Some services require *prior authorization*. *Deductible*, *copayment*, and *coinsurance amounts* must be paid to *your network provider* at the time you receive services. All *covered services* are subject to conditions, exclusions, limitations, terms and provision of this *contract*. *Covered service* must be *medically necessary* and not *experimental* or *investigational*.

Accidental Dental

Coverage will be provided for *dental service* expenses when a *member* suffers an *injury*, after the *member's effective date* of coverage, that results in:

1. Damage to his or her natural teeth; and
2. Expenses are incurred within twelve months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within twelve months of the accident. *Injury* to the natural teeth will not include any *injury* as a result of chewing.

Treatment for accidental dental is limited to \$3,000 per occurrence.

Ambulance Service Benefits

Covered service expenses will include *ambulance* services (ground or water - depending on the situation) for local ground transportation, transportation from home, scene of accident, or medical emergency:

1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*, in cases of emergency.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that is appropriate for the condition.
3. Transportation between *hospitals* or between a *hospital* and a *skilled nursing, rehabilitation facility and member's home* when *authorized* by Ambetter from Buckeye Health Plan.
4. When ordered by an employer, school, fire or public safety official and the *member* is not in a position to refuse; or
5. When a *member* is required by *us* to move from a *non-network provider* to a *network provider*.

Prior authorization is not required for emergency *ambulance* transportation. Note: Non-emergency *ambulance* transportation requires *prior authorization*. If you receive non-emergency services from non-network *ambulance providers*, you may be responsible for costs above the allowed charges.

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 medical transportation*.
3. *Ambulance* services provided for a *member's* comfort or convenience.
4. Non-emergency transportation excluding *ambulances* (for example, transport-van, taxi).
5. *Ambulette*.

Air Ambulance Service Benefits

Covered service expenses will include *ambulance* services for fixed wing and rotary wing air transportation from home, scene of accident, or medical emergency:

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

4. When ordered by an employer, school, fire or public safety official and the *member* is not in a position to refuse; or
5. When a *member* is required by *us* to move from a *non-network provider* to a *network provider*.

Prior authorization is not required for emergency *ambulance* transportation. Please Note: *You* should not be balance billed for services from a non-network *ambulance provider*, beyond *your* cost share, for air *ambulance* services.

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 medical transportation*.
3. *Air medical transportation*:
 - a. Outside of the 50 United States and the District of Columbia;
 - b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
 - c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States.
4. *Ambulance* services provided for a *member's* comfort or convenience.
5. Non-emergency transportation excluding *ambulances*.
6. *Ambulette*.

Benefit Limitations

Limitations may also apply to some *covered services* that fall under more than one *Covered Service* category. Please review all limits carefully. Ambetter from Buckeye Health Plan will not pay benefits for any of the services, treatments, items or supplies that exceed benefit limits. For example, pulmonary therapy has a limit of 20 outpatient visits per year, however, if it is rendered as part of a *physical therapy* (PT) visit, the visit would apply to the PT visit limit.

Chiropractic Services

We cover charges for chiropractic services. These services shall be provided at the request of the *member* who presents a condition of an orthopedic or neurological nature necessitating treatment for which falls within the scope of a licensed *medical practitioner*.

Clinical Trial Coverage

***Note:** For purposes of this section a *qualified individual* means 1.) an individual eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition 2.) either—(A) the referring *healthcare professional* is a participating *healthcare provider* and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described below; or (B) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described below.

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

- The *investigational* item or service itself;

- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient
- Items and services provided by the research sponsors free of charge for any enrollee in the trial; and
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

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

Covered clinical trials must be approved or funded by one of the following entities:

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

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

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

If one or more participating *providers* is participating in a clinical trial, nothing prevents *us* from requiring that a *qualified individual* participate in the trial through such a participating *provider* if accepted in the trial.

If an approved clinical trial is conducted outside the state, a *qualified individual* shall not be prohibited from participating in the approved clinical trial.

Benefits for an *eligible cancer clinical trial* do not, however, include the following:

- a) A health care service, item, or drug that is the subject of the cancer clinical trial or is provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
- b) An *investigational* or *experimental* drug or device that has not been approved for market by the United States Food and Drug Administration;
- c) Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
- d) An item or drug provided by the cancer clinical trial sponsors free of charge for any patient; or
- e) A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.

Contraception

All FDA-approved contraception methods (identified on www.fda.gov) are approved for *members* without *cost*

sharing as required under the *Affordable Care Act*. *Members* have access to the methods available and outlined on *our* Drug Formulary or Preferred Drug List; located within Ambetter.BuckeyeHealthPlan.com under Pharmacy Resources, without cost share. Some contraception methods are available through a *member's* medical benefit, including the insertion and removal of the contraceptive device, at no cost share to the *member*. Emergency contraception is available to *members* without a prescription and at no cost share to the *member*. Oral contraceptive coverage is provided in accordance with *Affordable Care Act* rules. If *you* are utilizing an oral contraceptive that is not on *our* formulary or that is on a tier higher than preventive tier, *you or your provider* can get in touch with *our* Prior Authorization team. *Our* Prior Authorization team will provide *you* with an override so that non-formulary or non-preferred medication will process at no cost to *you*. For further detail, please see "Family Planning Services," below.

Dental Benefits – Adults 19 years of age or older

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

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

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

Services not covered:

1. Out of *network* services;
2. *Dental services* that are not necessary or specifically covered;
3. Hospitalization or other facility charges;
4. *Prescription drugs* dispensed in the dental office;
5. Any dental procedure performed solely as a cosmetic procedure;
6. Charges for dental procedures completed prior to the *member's effective date* of coverage;
7. Services provided by an anesthesiologist;
8. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (wear), realignment of teeth, periodontal splinting, and gnathologic recordings;
9. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles;
10. Any artificial material implanted or grafted into soft tissue, surgical removal of implants, and implant-related services;
11. Sinus augmentation;
12. Surgical appliance removal;
13. Intraoral placement of a fixation device;
14. Oral hygiene instruction, tobacco counseling, nutritional counseling or high-risk substance abuse

- counseling;
15. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture;
 16. Any oral *surgery* that includes surgical endodontics (apicoectomy and retrograde filling);
 17. Analgesia (nitrous oxide);
 18. Removable unilateral dentures;
 19. Temporary procedures;
 20. Splinting;
 21. Temporal Mandibular Joint disorder (TMJ) appliances, therapy, films and arthorograms;
 22. Oral pathology laboratory;
 23. Consultations by the treating *provider* and office visits;
 24. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
 25. Veneers (bonding of coverings to the teeth);
 26. Orthodontic treatment procedures;
 27. Orthognathic *surgery*;
 28. Athletic mouth guards;
 29. Space maintainers;
 30. Dental procedures or restorations to alter or increase vertical dimension of occlusion; and,
 31. Dental procedures or restorations to restore or repair loss of tooth structure caused by abrasion, abfraction, or erosion.

Diabetic Care

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

Covered service expenses also include all *provider* prescribed *medically necessary* equipment and supplies used for the management and treatment of diabetes. See “Durable Medical Equipment, Prosthetics, Orthotic Devices, and Covered Medical Supply Expense Benefits” and “Preventive Care Expense Benefits.” Screenings for gestational diabetes are covered under “Preventive Care Expense Benefits.”

Dialysis Services

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

Covered expenses include:

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

Durable Medical Equipment, Prosthetics, Orthotic Devices, and Covered Medical Supply Expense Benefits

The supplies, equipment, and appliances described below are *covered services* under this benefit. If the supplies, equipment, and appliances include comfort, luxury, or convenience items or features which exceed what is *medically necessary* in *your* situation or needed to treat *your* condition, reimbursement will be based on the maximum allowable amount for a standard item that is a *covered service*, serves the same purpose, and is *medically necessary*. Any expense that exceeds the maximum allowable amount for the standard item which is a *covered service* is *your* responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates *your* condition. Repair, adjustment, and replacement of purchased equipment, supplies, or appliances as set forth below may be covered, as *approved by us*. The repair, adjustment, or replacement of the purchased equipment, supply, or appliance is covered if:

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

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

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

Benefits for repairs and replacement do not include the following:

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

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

Durable medical equipment

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

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

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

Exclusions:

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

1. Air conditioners.
2. Ice bags/coldpack pump.
3. Raised toilet seats.
4. Rental of equipment if the *member* is in a facility that is expected to provide such equipment.
5. Translift chairs.
6. Treadmill exerciser.
7. Tub chair used in shower.
8. Vehicle installations or modifications which may include, but are not limited to: adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.

Emergency Services

Services which we determine to meet the definition of *emergency services* will be covered, whether the care is rendered by a *network provider* or *non-network provider*. *Emergency services* rendered by a *non-network provider* will be covered as a *network service* and paid in accordance with the *eligible service expense* definition. You will be responsible for any applicable *coinsurance*, *copayment* or *deductible*.

Benefits are provided for treatment of *emergency medical conditions* and emergency screening and *stabilization* services without *prior authorization* for conditions that reasonably appear to a prudent layperson to constitute an *emergency medical condition* based upon the patient's presenting symptoms and conditions. Benefits for emergency care include, but are not limited to, facility costs and *physician* services, and supplies and *prescription drugs* charged by that facility.

Care and treatment provided once you are *stabilized* is no longer considered emergency care. Continuation of care from a *non-network provider* beyond that needed to evaluate or *stabilize your* condition in an emergency will be covered as a *non-network service* unless we authorize the *continuation* of care and it is *medically necessary*.

Medical and surgical supplies

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

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

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

Exclusions:

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

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

Orthotic devices

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

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

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

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

Exclusions:

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

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

Prosthetics

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

1. *Covered services* and supplies may include, but are not limited to: 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 Assist 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 calendar year, as required by the Women's Health and Cancer Rights Act. Maximums for *prosthetic devices*, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are *covered services*. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for

example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract *surgery* or *injury*; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of *surgery* are not considered contact lenses, and are not considered the first lens following *surgery*. If the *injury* is to one eye or if cataracts are removed from only one eye and the *member* selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.

6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (the first one following cancer treatment, not to exceed one per calendar year) when purchased through a participating *provider* or a *provider* approved by us.

Exclusions:

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

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

Penile prosthesis in *members* suffering impotency resulting from disease or *injury*

Family Planning Services

Covered service and supply expenses for family planning include:

1. Medical history review.
2. Physical examinations.
3. Laboratory tests related to physical examinations.
4. Contraceptive counseling.
5. All FDA-approved contraception methods are covered without *cost sharing* as outlined at www.fda.gov (see "Contraception" section above). This benefit contains both pharmaceutical and medical methods, including, but not limited to:
 - a. Intrauterine devices (IUD), including insertion and removal;
 - b. Barrier methods including: male and female condoms (Rx required from *provider*, limited to 30 per month), diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, and spermicide alone;
 - c. Oral contraceptives including the pill (combined pill and extended/continuous use), and the mini pill (Progestin only), patch;
 - d. Other hormonal contraceptives, including inserted and implanted contraceptive devices, hormone contraceptive injections, and the vaginal contraceptive ring;
 - e. Emergency contraception (the morning after pill);
 - f. FDA-approved tubal ligation; and
 - g. For *prescription drug* contraceptives.
6. Vasectomy and services related to this procedure.

Home Health Care Service Expense Benefits

Covered service and supplies for *home health care* are covered when *your physician* indicates *you* are not able to travel for appointments in a medical office. Coverage is provided for *medically necessary in-network care* provided at the *member's* home and includes the following:

1. Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
2. Medical/Social Services.
3. *Diagnostic Services*.
4. Nutritional Guidance.
5. *Home health aide services*. The *member* must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the *home health care provider*. Other

organizations may provide services only when *approved* by us, and their duties must be assigned and supervised by a professional nurse on the staff of the *home health care provider*.

6. Therapy services (except for *manipulation therapy* which will not be covered when rendered in the home). Home care visit limits specified in the *Schedule of Benefits* for home care services apply when therapy services are rendered in the home.
7. Medical/Surgical Supplies.
8. *Durable Medical Equipment*.
9. *Prescription Drugs* (only if provided and billed by a *home health care agency*).
10. Private Duty Nursing.
11. Sleep Studies.

At our option, we may *authorize* the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a *provider we authorize* before the purchase. If the equipment is purchased, the *member* must return the equipment to us when it is no longer in use.

Home infusion therapy will be paid only if *you* obtain prior *approval* from our home infusion therapy administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, *durable medical equipment*, and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes, but is not limited to: injections (intra-muscular, subcutaneous, and continuous subcutaneous), Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain management, and *chemotherapy*.

Exclusions and Limitations:

No benefits will be payable for charges related to *respite care*, *custodial care*, or educational care, under the *home health care service* Expense benefit. Non-covered services and supplies include, but are not limited to:

1. Food, housing, homemaker services, and home delivered meals.
2. Home or outpatient hemodialysis services (these are covered under Therapy Services).
3. *Physician* charges.
4. Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices).
5. Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting *home health care provider*.
6. Services provided by a *member* of the patient's *immediate family*.
7. Services provided by volunteer *ambulance* associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside.

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

Hospice Care Service Expense Benefits

Hospice care may be provided in the home or at a *hospice* facility where medical, social, and psychological services are given to help treat patients with a terminal *illness*. *Hospice* services include routine home care, continuous home care, inpatient *hospice*, and inpatient respite. To be eligible for *hospice* benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending *physician*. *Covered services* will continue if the *member* lives longer than six months.

When *approved* by your *physician*, *covered services* and supplies include the following:

- Skilled nursing services (by an R.N. or L.P.N.).
- *Diagnostic services*.
- Physical, speech, and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment, and appliances (benefits will not be covered for equipment when the *member* is in a facility that should provide such equipment).
- Counseling services.
- Inpatient confinement at a *hospice*.

- *Prescription drugs* given by the *hospice*.
- Home health aide.

Non-covered services include, but are not limited to:

- Services provided by volunteers.
- Housekeeping services.

Hospital Benefits

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

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

Infertility

Covered service expenses under this benefit are provided for *medically necessary* diagnostic and exploratory procedures to determine *infertility* including *surgical procedures* to correct a medically diagnosed disease or condition of the reproductive organs including, but not limited to, treatment of the following:

- Endometriosis;
- Collapsed/clogged fallopian tubes; or
- Testicular failure.

This benefit is subject to *deductible* and *coinsurance/copayment*.

No benefits will be payable for charges related to in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT).

Mammography Screening

Covered service expenses under this benefit are provided for two screening mammography views per breast to detect breast cancer in *members*. A screening mammography means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in an asymptomatic *member* and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. Coverage also includes the professional interpretation of film.

Coverage includes:

- a. If a *member* is at least thirty-five years of age but under forty years of age, one screening mammography;
- b. If a *member* is at least forty years of age but under fifty years of age, either of the following:
 - i. One screening mammography every two years; or
 - ii. If a licensed *physician* has determined that the *member* has risk factors to breast cancer, one screening mammography every year.
- c. If a *member* is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

Mastectomy Benefits

Covered service expenses for a mastectomy include 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 treatment of physical complications of all stages of mastectomy, including lymphedemas.

Maternity Coverage

Maternity coverage include *inpatient services*, *outpatient services*, and *physician* home visits and office services. These services are used for normal or complicated *pregnancy*, miscarriage, therapeutic abortion (abortion recommended by a *provider*), and ordinary routine nursery care for a healthy newborn. Abortion means the ending of a *pregnancy* before the birth of the infant. Miscarriage is a spontaneous abortion (occurs naturally and suddenly). A therapeutic abortion is one performed to save the life or health of the *member*, or as a result of incest or rape.

Coverage for the inpatient postpartum stay for *you* and *your* newborn child in a *hospital* will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care. *We* do not require that a *physician* or other healthcare *provider* obtain *prior authorization* for deliveries. An *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require notification.

When a decision is made to discharge a *member* or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to all follow-up care that is provided within seventy-two hours after discharge.

Physician-directed or advanced practice registered nurse-directed follow-up care after delivery is also covered. Services covered as follow-up care include physical assessment of the *member* and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any *medically necessary* and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The coverage applies to services provided in a medical setting or through *home health care* visits. The coverage shall apply to a *home health care* visit only if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if *your* attending *physician* or a certified nurse-midwife, if attending the *member* in collaboration with a *physician*, determines further inpatient postpartum care is not necessary for *you* or *your* newborn child, provided the following are met and the *member* concurs:

- In the opinion of *your* attending *physician*, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
 1. the antepartum, intrapartum, and postpartum course of the *member* and infant;
 2. the gestational stage, birth weight, and clinical condition of the infant;
 3. the demonstrated ability of the *member* to care for the infant after discharge; and
 4. the availability of post discharge follow-up to verify the condition of the infant after discharge.

Covered services include at-home post-delivery care visits at *your residence* by a *physician* or nurse performed no later than 72 hours following *you* and *your* newborn child's discharge from the *hospital*. Coverage for this visit includes, but is not limited to:

1. parent education;
2. assistance and training in breast or bottle feeding; and
3. performance of any maternal or neonatal tests routinely performed during the usual course of inpatient care for *you* or *your* newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the *physician's* office.

Newborn Charges

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

Newborns' and Mothers' Health Protection Act Statement of Rights

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

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, we may provide benefits for *covered service expenses* incurred for a shorter stay if the attending *provider* (e.g., *your physician, nurse, midwife, or physician assistant*), after consultation with the mother, discharges the mother or newborn earlier.

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

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 to Buckeye Health Plan at Member Services, 4349 Easton Way, Suite 300 Columbus, OH, 43219. In the event that a *member* fails to comply with this provision, we reserve our right to enforce this EOC on the bases of fraud, misrepresentation or false information, up to and including recoupment of all benefits that we paid on behalf of the surrogate during the time that the surrogate was insured under our policy, plus interest, attorneys' fees, costs and all other remedies available to us.

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

Medical Foods

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

Excluded are any other non-medical dietary formulas, oral nutritional supplements, special diets, prepared foods or meals, baby formula or food and formula for access problems.

Mental Health and Substance Use Disorder Benefits

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

Mental health services will be provided on an *inpatient* and *outpatient* basis and include treatable mental health conditions. These conditions affect the *member's* ability to cope with the requirements of daily living. If you need mental health and/or *substance use disorder* treatment, you may choose any *provider* participating in our mental

health *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* as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association and the most recent edition of the International Classification of Diseases and Related Health Problems (ICD).

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

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

Inpatient

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

Outpatient

1. Partial Hospitalization Program (PHP);
2. Intensive Outpatient Program (IOP);
3. Mental health day treatment;
4. Outpatient detoxification programs;
5. Evaluation and assessment for mental health and *substance use*;
6. Individual and group therapy, and marriage counseling for mental health and *substance use*;
7. Medication Assisted Treatment – combines behavioral therapy and medication to treat *substance use disorders*;
8. Medication management services;
9. Psychological and neuropsychological testing and assessment;
10. *Applied behavior analysis* for treatment of *autism spectrum disorders*;
11. *Telehealth and Virtual Care Services*, provided on the same basis and to the same extent (included cost shares) for the provision of in-person health care services;
12. Electroconvulsive Therapy (ECT);
13. *Transcranial Magnetic Stimulation (TMS)*; and
14. Assertive Community Treatment (ACT).

In addition, Integrated Care Management is available for all of *your* healthcare needs, including *behavioral health* and substance use. Please call 1-877-687-1189 (TTY/TDD 1-877-941-9236) to be referred to a care manager for an assessment.

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

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

Opioid Treatment

Care Management Services for Opioid Use Disorder

All *members* are eligible for free, comprehensive *care management* services to help manage and coordinate care for their opioid use disorders. Our *Care Management* team has specialty trained *behavioral health* clinicians that work with *members* and *providers* to identify needs and barriers to secure resources and improve access to care. *Members* can contact our Member Services team to enroll. Buckeye's specialty team may also proactively outreach *members* following inpatient admissions or emergency room visits related to their opioid use disorder. We can help you:

1. Better understand and manage *your* condition
2. Coordinate services
3. Locate community resources

Opioid Educational Tools

Buckeye's website has information and tools to assist *you* with locating *providers* and education related to Opioid Use Disorder. The educational content provides an overview of the various types of treatment available. Our Find a Provider Tool assists *members* with locating opioid treatment specialty *providers* in *your* preferred area.

Prior Authorization Process for Opioid Treatment

Outpatient services for monitoring drug therapy, also known as Medication Assisted Treatment (MAT), does not require *prior authorization*. Methadone maintenance is an example of this type of benefit. In addition, medication management services utilized for opioid treatment, such as psychiatric evaluations and medication follow-up appointments do not require *prior authorization*.

Medical and Surgical Expense Benefits

Medical *covered service expenses* include, but are not limited to, charges:

1. For *surgery* in a *physician's* office or at an *outpatient surgical facility*, including services and supplies.
2. Made by a *physician* for professional services, including *surgery*.
3. Made by an assistant surgeon.
4. For the professional services of a *medical practitioner*, including *surgery*.
5. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies*.
6. For *diagnostic services* using radiologic, ultrasonographic, or laboratory services.
7. For *chemotherapy* (including *oral chemotherapy*) and *radiation therapy* or treatment. We shall not provide coverage or impose *cost sharing* for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or *cost sharing* it imposes for intravenously administered or injected cancer medications.
8. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
9. For the cost and administration of an anesthetic.
10. For oxygen and its administration.
11. Excluding tooth extraction, we will treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint.
12. For reconstructive breast *surgery* charges as a result of a partial or total mastectomy for breast cancer.
13. For routine patient care for patients enrolled in an *eligible cancer clinical trial*.
14. For the following types of tissue transplants:
 - a. Cornea transplants.
 - b. Artery or vein grafts.
 - c. Heart valve grafts.
 - d. Prosthetic tissue replacement, including joint replacements.

- e. Implantable prosthetic lenses, in connection with cataracts.
15. Family planning for certain professional *provider* contraceptive services and supplies, including but not limited to, vasectomy, tubal ligation, and insertion or extraction of FDA-approved contraceptive devices.
16. Allergy testing and the different coverages may be found in Ambetter.BuckeyeHealthPlan.com; injections, and serum.
17. X-ray and other radiology services.
18. Magnetic Resonance Imaging (MRI).
19. CAT scans.
20. Positron emission tomography (PET scanning).
21. For routine care costs that are incurred in the course of a clinical trial that is deemed an *experimental or investigational treatment* if the services provided are otherwise considered *covered services* under the *contract*.
22. *Medically necessary telehealth services* subject to the same clinical and *utilization review* criteria, plan requirements and limitations as the same health care services when delivered to an insured in-person. *Telehealth services* provided by *Ambetter Telehealth* are subject to \$0 *copay*. *Telehealth services* not provided by *Ambetter Telehealth* would be subject to the same *cost sharing* as the same health care services when delivered to an insured in-person. Pursuant to federal regulation, the \$0 cost share does not apply to *members* enrolled in an HSA-eligible plan. Please review *your Schedule of Benefits* to determine if *your plan* is HSA-eligible.
23. Cytologic screenings for cervical cancer.
24. Cochlear Implants.
25. Vision correction as a result of *surgery* or accident.
26. *Medically necessary* services for complications arising from medical and surgical conditions.
27. Coverage for *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis.

If *your provider* has the capability, *your coverage* will include online visit services. *Covered services* include a medical consultation using the internet via a webcam, chat, or voice. Non-covered services include, but are not limited to, communications used for:

- Reporting normal lab or other test results;
- Office appointment requests;
- Billing, insurance coverage, or payment questions;
- Requests for referrals to doctors outside the online care panel;
- Benefit precertification; or
- *Physician to physician* consultation.

Medically Necessary Vision Services

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

Excluded services for routine and non-routine vision include:

- Visual Therapy.
- Any vision services, treatment, or materials not specifically listed as a *covered service*.
- Low vision services and hardware for adults.
- *Non-network* care, except when *authorized*.

Non-Routine Dental Services

Coverage for non-routine *dental services* for specified conditions is limited to the following:

1. Facility charges for *outpatient services* for the removal of teeth or for other dental processes if the patients' medical condition or the dental procedure requires a *hospital* setting to ensure the safety of the patient; or
2. *Dental services* for any of the following:
 - a. Transplant preparation.

- b. Initiation of immunosuppressive.
- c. Direct treatment of acute traumatic *injury*, cancer, or cleft palate.

Prescription Drug Expense Benefits

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

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

1. A *prescription drug*.
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *provider*.

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

Formulary or Prescription Drug List

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

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

For the most current Ambetter Formulary or Prescription Drug List or for more information about *our* pharmacy program, visit Ambetter.BuckeyeHealthPlan.com (under “For Member”, “Pharmacy Resources”) or call Member Services at 1-877-687-1189 (TTY/TTD 1-877-941-9236).

Non-Formulary and Tiered Formulary Contraceptives:

Under *Affordable Care Act*, *you* have the right to obtain contraceptives that are not listed on the formulary (otherwise known as “non-formulary drugs”) and tiered contraceptives (those found on a formulary tier other than “Tier 0 – no cost share”) at no cost to *you* on *your* or *your medical practitioner’s* request. To exercise this right, please get in touch with *your medical practitioner*. *You* can utilize the usual *prior authorization* request process. See “*Prior Authorization*” section for additional details.

Non-Formulary Prescription Drugs

Under *Affordable Care Act*, *you* have the right to request coverage of *prescription drugs* that are not listed on the plan formulary (otherwise known as “non-formulary drugs”). To exercise this right, please get in touch with *your medical practitioner*. *You* can utilize the usual *prior authorization* request process. See “*Prior Authorization*” section for additional details or *your maximum out of pocket*. There is no financial penalty for using non-formulary drugs; however, *you* will be responsible for regular Tier 3 *copay* for all non-formulary non-specialty drugs and regular Tier 4 *copay* for all non-formulary specialty drugs approved for use under *Affordable Care Act* mandated formulary exception rule.

Over-the-Counter (OTC) Prescriptions

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

How to Fill a Prescription

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

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

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

Mail Order Pharmacy

If *you* have more than one prescription *you* take regularly, *you* may select to enroll in *our* mail order delivery program. *Your* prescriptions will be safely delivered right to *your* door at no extra charge to *you*. For mail orders supplies of less than a 90-day supply, *you* will still be responsible for *your* regular *copayment/coinsurance*. Specialty drugs and other select drug categories are limited to 30-day supply when dispensed by retail or mail order. To enroll for mail order delivery or for any additional questions, call *our* mail order pharmacy at 1-888-624-1139. Alternatively, *you* can fill out an enrollment form and mail the form to the address provided at the bottom of the form. The enrollment form can be found on *our* Ambetter website. Once on *our* website, click on the section, "For Member," "Pharmacy Resources." The enrollment form will be located under "Forms."

Medication Balance-On-Hand

Medication refills are prohibited until a member's cumulative balance-on-hand is equal to or fewer than 15 days' supply of medication. This program operates in addition to any applicable medication quantity limit or refill guidelines.

Split-Fill Dispensing Program

Members are limited to 15-day supplies for the first 90 days when starting new therapy using certain medications (like oral oncology). *Members* pay half the 30-day cost-share for a 15-day supply, and would be responsible for the other half of the 30-day cost share for each additional 15-day supply. After 90 days, *members* will fill their medications for 30-day supplies.

Lock-in program

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

Prescription Drug Exception Process

1. 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.

2. Expedited exception request

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

3. External exception request review

If we deny a request for a standard exception or for an expedited exception, the *member*, the *member's* designee, or the *member's* prescribing *physician* may request that the original exception request and subsequent denial of such request be reviewed by an *independent review organization (IRO)*.

For a *prior approval* related to a chronic condition, the *approval* for an approved drug will be honored for the lesser of 12 months or the last day of the *covered person's* enrollment under the *contract*.

Non-Covered Services and Exclusions:

No benefits will be paid under this benefit subsection for services provided or expenses incurred:

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance unless such treatment is listed on the formulary.
2. For weight loss *prescription drugs* unless otherwise listed on the formulary.
3. For immunization agents, blood, or blood plasma, except when used for preventive care and listed on the formulary.
4. For medication that is to be taken by the *member*, in whole or in part, at the place where it is dispensed.
5. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
6. For a refill dispensed more than 12 months from the date of a *physician's* order.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are on the formulary.
9. For drugs labeled "Caution - limited by federal law to *investigational* use" or for *investigational* or *experimental* drugs.
10. For any drug that we identify as therapeutic duplication through the drug *utilization review* program.
11. For more than a 30-day supply when dispensed in any one prescription or refill, or for maintenance drugs, up to 90-day supply when dispensed by mail order or a retail pharmacy.
12. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
13. Foreign prescription medications, except those associated with an *emergency medical condition* while *you* are travelling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this document, if obtained in the United States.
14. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventive treatment is related to *member's* vacation during out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
15. For medications used for cosmetic purposes.
16. For *infertility* drugs unless otherwise listed on the formulary.
17. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
18. For drugs or dosage amounts determined by Ambetter to be ineffective, unproven, or unsafe for the indication for which they have been prescribed, regardless of whether such drugs or dosage amounts have been approved by any governmental regulatory body for that use.

19. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
20. For any injectable medication or biological product that is not expected to be self-administered by the *member* at *member's* place of *residence* unless listed on the formulary.
21. For any drug related to *surrogate pregnancy* for non-covered persons.
22. Medication refills where a *member* has more than 15 days' supply of medication on hand.
23. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
24. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status. To facilitate appropriate benefit use and prevent overutilization, *member's* participation in lock-in status will be determined by review of pharmacy claims.
25. Human growth hormone for children born small for gestational age.
26. Compound drugs unless there is at least one ingredient that requires a prescription.

Pediatric Vision Expense Benefits

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

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

Please refer to *your Schedule of Benefits* for a detailed list of *cost sharing*, annual maximum and appropriate service limitations. To see which vision *providers* are part of the *network*, please visit Ambetter.BuckeyeHealthPlan.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*; and
4. Lasik surgery.

IMPORTANT: If you opt to receive *vision care services or vision care materials* that are not covered benefits under this plan, a participating vision care *provider* may charge you his or her normal fee for such services or materials. Prior to providing you with *vision care services or vision care materials* that are not covered benefits, the vision care *provider* will provide you with an estimated cost for each service or material upon your request.

Preventive Care Expense Benefits

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

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

Benefits for preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any *deductibles*, *cost sharing* percentage provisions, and *copayment amounts* under the *contract* when the services are provided by a *network provider*. Whether something is preventive is determined by the claim service data submitted by the *provider*. If a service is considered diagnostic or non-preventive, *your plan copayment, coinsurance, and deductible* will apply. It is important to know what type of service you are 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.

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

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

Covered Preventive Services for Adults include:

1. Abdominal Aortic Aneurysm one-time screening for adults of specified ages who have ever smoked;
2. Alcohol misuse screening and counseling;

3. Aspirin use to prevent cardiovascular disease for adults of certain ages;
4. Blood pressure screening for all adults;
5. Cholesterol screening for adults of certain ages or at higher risk;
6. Colorectal Cancer screening for adults over 50;
7. Depression screening for adults;
8. Type 2 Diabetes screening for adults with high blood pressure;
9. Diet counseling for adults at higher risk for chronic disease;
10. Hepatitis B screening for adults at high risk, including adults from countries with 2% or more Hepatitis B prevalence, and U.S.-born adults not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence;
11. Hepatitis C screening for adults at increased risk, and one time for everyone born 1945-1965;
12. HIV screening for all adults at higher risk;
13. Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
 - Diphtheria;
 - Hepatitis A;
 - Hepatitis B;
 - Herpes Zoster;
 - Human Papillomavirus;
 - Influenza (Flu Shot);
 - Measles, Mumps, Rubella;
 - Meningococcal;
 - Pneumococcal;
 - Tetanus, Diphtheria, Pertussis; and
 - Varicella.
14. Lung cancer screening for adults 55-80 at high risk for lung cancer because the adult is a heavy smoker or has quit in the past 15 years;
15. Obesity screening and counseling for all adults;
16. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;
17. *Tobacco* or *nicotine* use screening for all adults and cessation interventions for *tobacco* or *nicotine* users; and
18. Syphilis screening for all adults at higher risk.

Covered Preventive Services for Women and Pregnant Women include:

1. Anemia screening on a routine basis for pregnant *members*;
2. Urinary tract or other infection screening for pregnant *member*;
3. BRCA counseling about genetic testing for *members* at higher risk;
4. One cytologic screening per year or more often if recommended by a *physician*;
5. A baseline mammogram for *members* 35 to 39 years of age. Breast Cancer Mammography screenings every 1 to 2 years for *members* over 40. A mammogram at the age and intervals considered *medically necessary* by the *member's* health care *provider* for a *member* under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors;
6. Breast Cancer Chemoprevention counseling for *members* at higher risk;
7. Breastfeeding comprehensive support and counseling from trained *providers*, as well as access to breastfeeding supplies, for pregnant and nursing *members*;
8. Cervical Cancer screening for sexually active *members*;
9. Chlamydia Infection screening for younger *members* and other *members* at higher risk;
10. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care *provider* for *members* with reproductive capacity (not including abortifacient drugs);
11. Domestic and interpersonal violence screening and counseling for all *members*;
12. Folic Acid supplements for *members* who may become pregnant;
13. Gestational diabetes screening for *members* 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;

14. Gonorrhea screening for all *members* at higher risk;
15. Hepatitis B screening for pregnant *members* at their first prenatal visit;
16. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active *members*;
17. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for *members* with normal cytology results who are 30 or older;
18. Coverage for *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis;
19. Rh Incompatibility screening for all pregnant *members* and follow-up testing for *members* at higher risk;
20. *Tobacco* or *nicotine use* screening and interventions for all *members*, and expanded counseling for pregnant *tobacco users*;
21. Sexually Transmitted Infections (STI) counseling for sexually active *members*;
22. Syphilis screening for all pregnant *members* or other *members* at increased risk; and
23. Well-*member* visits to obtain recommended preventive services.

Covered Preventive Services for Children include:

1. Alcohol and drug use assessments for adolescents;
2. Autism screening for children at 18 and 24 months;
3. Behavioral assessments for children of all ages. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
4. Blood pressure screening for children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
5. Cervical Dysplasia screening for sexually active adolescents;
6. Congenital Hypothyroidism screening for newborns;
7. Depression screening for adolescents;
8. Developmental screening for children under age 3, and surveillance throughout childhood;
9. Dyslipidemia screening for children at higher risk of lipid disorders. Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
10. Fluoride Chemoprevention supplements for children without fluoride in their water source;
11. Gonorrhea preventive medication for the eyes of all newborns;
12. Hearing screening for all newborns;
13. Height, weight, and Body Mass Index measurements for children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
14. Hematocrit or Hemoglobin screening for children;
15. Hemoglobinopathies or sickle cell screening for newborns;
16. Hepatitis B screening for adolescents at high risk, including adolescents from countries with 2% or more Hepatitis B prevalence, and U.S.-born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence: 11-17 years;
17. HIV screening for adolescents at higher risk;
18. Hypothyroidism screening for newborns;
19. Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
 - Diphtheria, Tetanus, Pertussis;
 - Haemophilus influenzae type b;
 - Hepatitis A;
 - Hepatitis B;
 - Human Papillomavirus;
 - Inactivated Poliovirus;
 - Influenza (Flu Shot);
 - Measles, Mumps, Rubella;
 - Meningococcal;
 - Pneumococcal;
 - Rotavirus; and
 - Varicella.
20. Iron supplements for children ages 6 to 12 months at risk for anemia;

21. Lead screening for children at risk of exposure;
22. Medical history for all children throughout development. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
23. Obesity screening and counseling;
24. Oral health risk assessment for young children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years;
25. Phenylketonuria (PKU) screening for this genetic disorder in newborns;
26. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
27. Tuberculin testing for children at higher risk of tuberculosis. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years; and
28. Vision screening for all children.

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

Notification

As required by PHS Act section 2715(d)(4), we will provide 60 days advance notice to *you* before any material modification will become effective, including any changes to preventive benefits covered under this *contract*.

You may access *our* website or Member Services at 1-877-687-1189 (TTY/TDD 1-877-941-9236) to get the answers to many of *your* frequently asked questions regarding preventive services. *Our* website has resources and features that make it easy to get quality care. *Our* website can be accessed at Ambetter.BuckeyeHealthPlan.com.

You may also access the Federal Government's website at www.healthcare.gov/coverage/preventive-care-benefits/ to obtain current information.

Radiology, Imaging and Other Diagnostic Testing

Medically necessary radiology services, imaging and tests performed for diagnostic reasons are a covered benefit (e.g., X-ray, MRI, CT scan, PET/SPECT, mammogram, ultrasound). *Prior authorization* may be required, see the *Schedule of Benefits* for details. Note: Depending on the service performed, two bills may be incurred - both subject to any applicable *cost sharing* - one for the technical component (the procedure itself) and another for the professional component (the reading/interpretation of the results by a *physician* or other qualified practitioner). *The* total benefit for a screening mammography shall not exceed one hundred thirty per cent of the Medicare reimbursement rate in this state for screening mammography. If there is more than one Medicare reimbursement rate in this state for screening mammography or a component of a screening mammography, the reimbursement limit shall be one hundred thirty per cent of the lowest Medicare reimbursement rate in this state.

Rehabilitation and Skilled Nursing Facility Expense Benefits

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the *member's* ability to function as independently as possible; including skilled rehabilitative nursing care, *physical therapy*, *occupational therapy*, *speech therapy*, and services of a social worker or psychologist. The goal is to obtain practical improvement, or maintain the *member's* abilities, in a reasonable length of time in the appropriate inpatient setting.

Covered service expenses include services provided or expenses incurred for *rehabilitation* services (including *cardiac rehabilitation*) or confinement in a *skilled nursing facility*, subject to the following limitations:

1. *Covered service expenses* available to a *member* while confined primarily to receive *rehabilitation* are limited to those specified in this provision.
2. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *skilled nursing facility* for:
 - a. Daily room and board and nursing services.
 - b. *Diagnostic services*.
 - c. Drugs and medicines that are prescribed by a *physician*, filled by a licensed pharmacist and approved by the U.S. Food and Drug Administration.

3. *Covered service expenses* for non-provider facility services are limited to charges incurred for the professional services of *rehabilitation medical practitioners*.

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

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

Exclusions:

Non-covered services for physical medicine and *rehabilitation* include, but are not limited to:

1. Admission to a *hospital* mainly for *physical therapy*; or
2. Long term *rehabilitation* in an inpatient setting.

Limitations:

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

Habilitation Expense Benefits

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

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

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*.

Habilitative developmental services examples include, but are not limited to, toileting, dressing, using fine motor skills, crawling, walking, categorization, expressing oneself (making wants and needs known), picture recognition, identifying letters, numbers, shapes, etc., appropriate play skills and coping mechanisms.

Respite Care Expense Benefits

Respite care is covered on an inpatient or home basis to allow temporary relief to family members from the duties of caring for a *covered person*. Respite days that are applied toward the *deductible* are considered benefits provided and shall apply against any maximum benefit limit for these services. See the *Schedule of Benefits* for benefit levels or additional limits.

Second Medical Opinion

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

1. Whenever a minor *surgical procedure* is recommended to confirm the need for the procedure;
2. Whenever a serious *injury* or *illness* exists; or

3. Whenever *you* find that *you* are not responding to the current treatment plan in a satisfactory manner.

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

Sleep Studies

Sleep studies are covered when determined to be *medically necessary*; *prior authorization* may be required.

Note: A sleep study can be performed either at home or in a facility.

Social Determinants of Health Supplemental Benefits

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

Social determinants of health benefits and services may be offered to *members* through the “My Health Pays” wellness program and through local health plan websites. Additionally through the “My Health Pays” wellness program, *you* can earn rewards for being more active in *your* health. *Members* may receive notifications about available benefits and services through emails from local health plans and through the “My Health Pays” notification system. To inquire about these benefits and services or other benefits available, *you* may visit *our* website at Ambetter.BuckeyeHealthPlan.com or by contacting Member Services at 877-687-1189 (Relay Ohio/TTY 1-877-941-9236).

Transplant Expense Benefits

Covered Services For Transplant Service Expenses:

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

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

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

If we determine that a *member* is an appropriate candidate for a *medically necessary* transplant, medical service expense benefits will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting of the organ from the donor.
3. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
4. Including outpatient *covered services* related to the transplant *surgery*, pre- transplant laboratory testing and treatment; such as high dose *chemotherapy*, peripheral stem cell collection, and other immunosuppressive drug therapy, etc.
5. Pre-transplant stabilization, meaning an inpatient stay to be *medically stabilized* 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. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.
8. All costs incurred and medical expenses by the donor; shall be paid under the transplant recipient policy, this excludes travel, lodging, food, mileage. Please see transplant travel expense policy for outlined details on reimbursement limitations. (www.Ambetter.com).

These medical expenses are covered to the extent that the benefits remain and are available under the *member's contract*, after benefits for the *member'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 *member's contract*.

Ancillary "Center Of Excellence" Service Benefits:

A *member* may obtain services in connection with a transplant from any *physician*. However, if a transplant is performed in a *Center of Excellence*:

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

Non-Covered Services and Exclusions:

No benefits will be provided or paid under these Transplant Expense Benefits:

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

4. To keep a donor alive for the transplant operation, except when *authorized* through the *Center of Excellence*.
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
6. Related to transplants *unauthorized* though the *Center of Excellence* and is not included under this provision as a transplant.
7. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (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 *unauthorized* facility or not obtained through the *Center of Excellence*.
9. For any transplant services and/or travel related expenses for *member* and donor, when preformed outside of the United States.
10. The following ancillary items listed below, will not be subject to *member* reimbursement under this policy:
 - a. Alcohol/tobacco
 - b. Car Rental (unless pre-approved by Case Management)
 - c. Vehicle Maintenance for motorized and hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.)
 - d. Parking, such as but not limited to hotel, valet or any offsite parking other than *hospital*.
 - e. Storage rental units, temporary housing incurring rent/mortgage payments.
 - f. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
 - g. Speeding tickets
 - h. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
 - i. For any services related to pet care, boarding, lodging, food, and/or travel expenses; other than those related to certified/registered service animal(s).
 - j. Expenses for persons other than the patient and his/her covered companion
 - k. Expenses for lodging when *member* is staying with a relative
 - l. Any expense not supported by a receipt
 - m. Upgrades to first class travel (air, bus, and train)
 - n. Personal care items (e.g., shampoo, deodorant, clothes)
 - o. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA pre-check, and early check-in boarding fees, extra baggage fees.
 - p. Souvenirs (e.g., t-shirts, sweatshirts, toys)
 - q. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type.
 - r. All other items not described in the policy as eligible expenses
 - s. Any fuel costs / charging station fees for electric cars.

Organ Transplant Medication Notification

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

Urgent care includes *medically necessary services by in-network providers and services provided at an Urgent Care Center*, including facility costs and supplies, or care for a condition that is not an emergency, but is an unforeseen medical *illness, injury*, or condition that requires immediate care when the *member's primary care provider* is unavailable or inaccessible. Urgent care is covered at *network hospitals, network urgent care centers, or network providers' offices*, but *your zero cost sharing Preventive Care Benefits* may not be used at an *Urgent Care Center*. Urgent care received at any *hospital emergency department* is not covered unless *authorized* in advance by us.

Members are encouraged to contact their *primary care provider* for an appointment before seeking care from another *provider*, but contracted *urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *primary care provider* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-877-687-1189. The 24/7 Nurse Advice Line is available twenty-four (24) hours a day, seven (7) days a week. A registered nurse can help *you* decide the kind of care most appropriate for *your* specific need.

Urgent care is not covered for services received by a *non-network provider* or at an out-of-*network* facility.

Emergency Room Services

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

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

Vision Expense Benefits

Routine Vision Adult 19 years of age or older

Coverage for vision services is provided for adults, age 19 and older, from a *network provider*.

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

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

Services not covered:

1. Visual therapy;
2. Low vision services and hardware for adults;
3. *Non-network* care without *prior authorization*; and
4. Lasik surgery.

IMPORTANT: If *you* opt to receive *vision care services or vision care materials* that are not covered benefits under this plan, a participating vision care *provider* may charge *you* his or her normal fee for such services or materials.

Prior to providing *you* with *vision care services* or *vision care materials* that are not covered benefits, the vision care *provider* will provide *you* with an estimated cost for each service or material upon *your* request.

For additional information about *covered vision services*, participating vision vendor *providers*, call Member Services at 1-877-687-1189 (TTY/TDD 1-877-941-9236).

Wellness and Other Program Benefits

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

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

You may obtain information regarding the particular programs available at any given time by visiting *our* website at Ambetter.BuckeyeHealthPlan.com or by contacting Member Services by telephone at 877-687-1189 (Relay Ohio/TTY 1-877-941-9236). The benefits are available as long as coverage remains active, unless changed by *us* as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All *members* are automatically eligible for program benefits upon obtaining coverage. The programs are optional, and the benefits are made available at no additional cost to the *members*. The programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change by *us* through updates available on *our* website or by contacting *us*.

Care Management Programs

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

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

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

If *you* think *you* could benefit from *our Care Management* program, please call Member Services at 1-877-687-1189 (TTY/TDD 1-877-941-9236).

Prior Authorization

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

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

Prior Authorization Required

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

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

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

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

1. At least 5 days prior to an elective or scheduled admission as an inpatient in a *hospital, extended care or rehabilitation facility*, or *hospice facility* or as soon as reasonably possible.
2. At least 30 days prior to the initial evaluation for organ transplant services or as soon as reasonably possible.
3. At least 30 days prior to receiving clinical trial services or as soon as reasonably possible.
4. Within 24 hours (or as soon as reasonably possible) of any inpatient admission, including emergent inpatient admissions.
5. At least 5 days prior to the start (or as soon as reasonably possible) of *home health care* except those *members* needing *home health care* after *hospital* discharge.

After *prior authorization* has been requested, *we* will notify *you* and *your provider* if the request has been *approved* or *denied* as follows:

1. For *urgent care services*, within 48 hours of receipt of the request.
2. For urgent concurrent review within 24 hours of receipt of the request.
3. For non-urgent *pre-service* requests within 10 days, of receipt of the request.
4. For *post-service* requests, within 30 days of receipt of the request.

As used in this section, ***urgent care service*** means a *medical care* or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:

1. Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or
2. In the opinion of a *physician* with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

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

How to Obtain Prior Authorization

It is *your* responsibility to obtain *prior authorization* or to confirm that a *network provider* has obtained *prior authorization* on *your* behalf. Contact *us* by telephone at 1-877-687-1189 (TTY/TDD 1-877-941-9236) before the service or supply is provided to *you*.

Electronic Procedure

Providers will have access to *prior authorization* forms through the *provider* portal that can be submitted to *us* and accepted for review through the same portal. *We* will provide an electronic receipt to the *provider* confirming receipt of the *prior authorization* request. If *we* request additional information, the *provider* must provide acknowledgement of the request for additional information to *us*.

If there is an operational difficulty, such as limited internet connectivity, or a financial hardship that prevents the *provider* from utilizing the electronic procedure, the *provider* may contact *us* to develop an appropriate process for receiving *prior authorization* requests.

Failure to Obtain Prior Authorization

Failure to comply with the *prior authorization* requirements will result in benefits being denied. If *you* disagree with *our* decision, *you* may *appeal* pursuant to the Appeals and Grievance Procedures section.

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

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

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*. *We* will not retroactively deny *prior authorizations* as long as the *authorization* was obtained based on complete and accurate submission of all necessary information relative to an eligible *member* and the *provider* renders services in good faith and pursuant to the *authorization* and all of the terms and conditions of the *provider's contract* with *us*.

Services from Non-Network Providers

Except for *emergency medical services*, *we* do not normally cover services received from *non-network providers*. If a situation arises where a *Covered Service* cannot be obtained from a *Network Provider* located within a reasonable distance, *we* may provide a *prior authorization* for *you* to obtain the service from a *Non-Network Provider* at no greater cost to *you* than if *you* went to a *Network Provider*. If *Covered Services* are not available from a *network provider*, ***you are responsible for ensuring that your Primary Care provider has requested prior authorization from us before you receive services from a non-network provider.*** Otherwise *you* will be responsible for all charges incurred.

Appeal of Prior Authorization Denial

Prior Authorization denials for *urgent care* will be considered within 48 hours after receipt of the *appeal* and for non-urgent care within 10 days of receipt of the *appeal*. The *appeal* will be between the *provider* requesting the service in question and a clinical peer. If the *appeal* does not resolve the disagreement, either the *member* or the *member's authorized representative* may request an *external review*. Please refer to the Appeals and Grievance Procedures section for additional details.

General Non-Covered Services and Exclusions

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *member* in the absence of insurance covering the charge.
2. Expenses, fees, taxes or surcharges imposed on the *Member* by a *Provider* (including a *Hospital*) but that are actually the responsibility of the *Provider* to pay.
3. Any services performed for a *member* by a *member's immediate family*.
4. Any services not identified and included as *covered service expenses* under the *contract*. You will be fully responsible for payment for any services that are not *covered service expenses*.
5. Any services where other coverage is primary to Ambetter from Buckeye Health Plan must be first paid by the primary payor prior to consideration for coverage under Ambetter.
6. Any *non-medically necessary* court ordered care for a medical/surgical or mental health/*substance use disorder* diagnosis, unless required by state law.

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*, except as expressly provided for under the *contract's* Termination section.
2. For any portion of the charges that are in excess of the *eligible service expense*.
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*.
4. For cosmetic breast reduction or augmentation, except for the *medically necessary* treatment of Gender Dysphoria.
5. For the reversal of sterilization and vasectomies.
6. For non-therapeutic abortion.
7. For expenses for television, telephone, or expenses for other persons.
8. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
9. For telephone consultations, except those meeting the definition of *Telehealth* and *Virtual Care services*, or for failure to keep a scheduled appointment.
10. For *dental service* expenses, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Medical Service Expense Benefits.
11. For *cosmetic treatment*, except for *medically necessary reconstructive surgery* that is incidental to or follows *surgery* or an *injury* or is performed to correct a birth defect.
12. For diagnosis or treatment of learning disabilities.
13. For diagnosis or treatment of nicotine addiction, except as expressly provided for under Preventive Care Expense Benefits.
14. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
15. While confined primarily to receive *rehabilitation*, *custodial care*, educational care, or nursing services (unless expressly provided for in this *contract*).
16. For vocational or recreational therapy, vocational *rehabilitation*, outpatient *speech therapy*, or *occupational therapy*, except as expressly provided for in this *contract*.
17. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.

18. For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
19. For *experimental or investigational treatment(s) or unproven services*. The fact that an *experimental or investigational treatment or unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment or unproven service* for the treatment of that particular condition.
20. For treatment received outside the United States, except for a medical emergency while traveling for up to a maximum of 90 consecutive days.
21. As a result of an *injury*, disease, defect, or ailment arising out of and in the course of employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If workers' compensation insurance is not available to *you*, then this exclusion does not apply. This exclusion applies if *you* receive the benefits in whole or in part. This exclusion also applies whether or not *you* claim the benefits or compensation. It also applies whether or not *you* recover from any *third party*. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's* workers' compensation claim, this exclusion will still apply unless that denial is *appealed* to the proper governmental agency and the denial is upheld by that agency.
22. Surrogacy/Gestational Carrier Arrangement. The following health care services, including supplies and medication to a non-covered person serving as a *surrogate/gestational carrier* pursuant to a *surrogacy/gestational carrier arrangement* with a *member* are excluded. This exclusion applies to all health care services, supplies and medication to the non-covered *surrogate/gestational carrier* including, but not limited to:
 - a. Prenatal care;
 - b. Intrapartum care (or care provided during delivery and childbirth);
 - c. Postpartum care (or care for the *surrogate/gestational carrier* following childbirth);
 - d. Mental Health Services related to the *surrogacy/gestational carrier arrangement*;
 - e. Expenses relating to donor semen, including collection and preparation for implantation;
 - f. Donor gamete or embryos or storage relating to a *surrogacy/gestational carrier arrangement*;
 - g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy/gestational carrier arrangement*;
 - h. Preimplantation genetic diagnoses relating to a *surrogacy/gestational carrier arrangement*;
 - i. Any complications of the *surrogate/gestational carrier* resulting from the *pregnancy*; or
 - j. Any other health care services, supplies and medication relating to the *surrogacy/gestational carrier arrangement*.

Any and all health care services, supplies or medication provided to any child birthed by a *surrogate/gestational carrier* as a result of a *surrogacy/gestational carrier arrangement* are also excluded. This exclusion shall not apply, where a *member* possessing an active policy with *us* is the intended parent of the child and/or the child possesses an active policy with *us* at the time of birth.

23. For fetal reduction *surgery*.
24. Except as specifically identified as a *covered service expense* under the *contract*, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
25. 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.
26. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status. To facilitate appropriate benefit use and prevent overutilization, *member's* participation in lock-in status will be determined by review of pharmacy claims.
27. For any injectable medication or biological product that is not expected to be self-administered by the *member* at *member's* place of *residence* unless listed on the formulary. For court ordered testing or care unless *medically necessary*.

28. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a *member's* own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
29. Services or care provided or billed by a school or *custodial care* center for the developmentally disabled.
30. Bariatric *surgery*.
31. For diagnostic testing, laboratory procedures, screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment. This exclusion does not apply to preventive services.
32. Biofeedback.
33. Human growth hormone for children born small for gestational age.
34. Surgical treatment of Gynecomastia
35. For any medicinal and recreational use of cannabis or marijuana.
36. Vehicle installation or modifications which may include, but not limited to: adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.
37. For all health care services obtained at an *urgent care center* that is a *non-network provider*.

Termination

Termination of Contract

All coverage will cease on termination of this *contract*. This *contract* will terminate on the earliest of:

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*;
2. The date *you* are no longer eligible for coverage --- the last day of coverage is the last day of the month following the month in which the notice is sent by *us* unless *you* request an earlier termination *effective date*;
3. For a Dependent Child Reaching the Limiting Age of 26, Coverage under this *contract*, for a Dependent Child, will terminate at 11:59 p.m. on the last day of the year in which the Dependent Child reaches the limiting age of 26; or
4. *You* obtain other *minimum essential coverage*.

Refund upon Cancellation

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

Discontinuance

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

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

Notification Requirements

It is the responsibility of *you* or *your* former *dependent member* to notify *us* within 31 days of *your* legal divorce or *your dependent member's* marriage. *You* must notify *us* of the address at which their continuation of coverage should be issued.

Right of Reimbursement

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

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

However, if payment by or for the *third party* has not been made by the time we receive acceptable *proof of loss*, we will pay regular *contract* benefits, as outlined in our Claims section and pursuant to Ohio Prompt Payment Law, for the *member's loss*. By accepting benefits under this *contract*, the *member* specifically acknowledges our right of reimbursement. This right of reimbursement attaches when we have provided health care benefits for expenses incurred due to *third party injuries* and the *member's* or the *member's* representative has recovered any amounts from any source. We will have the right to be reimbursed to the extent permitted by Ohio law of benefits we provided or paid for the *illness* or *injury* if the *member* subsequently receives any payment from any *third party*. The *member* (or the guardian, legal representatives, estate, or heirs of the *member*) shall promptly reimburse us from the settlement, judgment, or any payment received from any *third party*. These sources include, but are not limited to:

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

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

1. To fully cooperate with us in order to obtain information about the *loss* and its cause.
2. To immediately inform us in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.
3. To include the amount of benefits paid by us on behalf of a *member* in any claim made against any *third party*.
4. That we:
 - a. Will have a lien on all money received by a *member* in connection with the *loss* to the extent permitted by Ohio law.
 - b. May give notice of that lien to any *third party* or *third party's* agent or representative.
 - c. Will have the right to intervene in any suit or legal action to protect our rights.

Furthermore, as a condition of our payment, we may require the *member* or the *member's* guardian (if the *member* is a minor or legally incompetent) to execute a written reimbursement agreement. However, the terms of this provision remain in effect regardless of whether or not an agreement is actually signed.

We will not pay attorney fees or costs associated with the *member's* claim or lawsuit unless we previously agreed in writing to do so.

If a dispute arises as to the amount a *member* must reimburse us, the *member* (or the guardian, legal representatives, estate, or heirs of the *member*) agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by us until the dispute is resolved. Additionally, either party may file an action pursuant to Ohio law to resolve any issue related to the distribution of any money recovered from the *third party*.

However, if less than the full value of the *loss* is recovered because of comparative negligence, diminishment due to a party's liability pursuant to Ohio law, or by reason of the collectability of the full value of the claim for *injury*, death, or *loss* to person resulting from limited liability insurance or any other cause, *our* reimbursement amount shall decrease in the same proportion as the *member's* interest.

Coordination of Benefits

The Coordination of Benefits (COB) provision applies when *you* have healthcare coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its contract terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100 percent of the total Allowable Expense.

Definitions

For the purpose of this Section, the following definitions shall apply:

- A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for *members* of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.
1. Plan includes: Group and non-group insurance contracts; Health insuring corporation (HIC) contracts; Coverage under group or non-group closed panel plans (whether insured or uninsured); *Medical care* components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan as permitted by law.
 2. Plan does not include: *Hospital* indemnity coverage or other fixed indemnity coverage; Accident only coverage; Specified disease or specified accident coverage; Supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; School accident-type coverage; Non-medical components of long term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1 and 2 above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- B. This Plan means, in a COB provision the part of the contract providing the healthcare benefits to which the COB provision applies and which may be reduced because of the benefits of *other plans*. Any other part of the contract providing healthcare benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when *you* have healthcare coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any *other plan* without considering any *other Plan's* benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.
- D. Allowable Expense is a healthcare expense, including *deductibles*, *coinsurance*, and *copayments*, that is covered at least in part by any Plan covering *you*. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering *you* is not an Allowable Expense. In addition, any expense that a *provider* by law or in accordance with a contractual agreement is prohibited from charging *you* is not an Allowable Expense. The following are examples of expenses that are not Allowable Expenses:
1. The difference between the cost of a semi-private *hospital* room and a private *hospital* room is not an Allowable Expense, unless one of the Plans provides coverage for private *hospital* room expenses.
 2. If *you* are covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar

reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

3. If *you* are covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 4. If *you* are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the *provider* has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the *provider's* contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
 5. The amount of any benefit reduction by the Primary plan because *you* have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and *preferred provider* arrangements.
- E. Closed Panel Plan is a Plan that provides healthcare benefits to *you* primarily in the form of services through a panel of *providers* that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other *providers*, except in cases of emergency or referral by a panel *member*.
- F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When *you* are covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any *other plan*.
- B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan *hospital* and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-*network* benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that *other Plan*.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:

1.) Non-Dependent or Dependent.

The Plan that covers *you* other than as a *dependent*, (for example as an employee, *member*, policyholder, subscriber, or retiree) is the Primary Plan and the Plan that covers *you* as a *dependent* is the Secondary Plan. However, if *you* are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering *you* as a *dependent*, and primary to the Plan covering *you* as other than a *dependent*, then the order of benefits between the two plans is reversed so that the plan covering *you* as an employee, *member*, policyholder, subscriber, or retiree is the Secondary Plan and the *other plan* is the Primary Plan.

2.) Dependent Child Covered Under More Than One Plan.

Unless there is a court decree stating otherwise, when a child is covered by more than one Plan the order of benefits is determined as follows:

- a. For a child whose parents are married or are living together, whether or not they have ever been married:
 - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
 - However, if one *spouse's* Plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that Plan.
- b. For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - i. If a court decree states that one of the parents is responsible for the child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - ii. If a court decree states that both parents are responsible for the child's healthcare expenses or healthcare coverage, the provisions of paragraph a. above shall determine the order of benefits;
 - iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the child, the provisions of paragraph a. above determine the order of benefits; or
 - iv. If there is no court decree allocating responsibility for the child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
 - The Plan covering the Custodial Parent, first;
 - The Plan covering the *spouse* of the Custodial Parent, second;
 - The Plan covering the noncustodial parent, third; and then
 - The Plan covering the *spouse* of the noncustodial parent, last.
- c. For a child covered under more than one Plan of individuals who are not the parents of the child, the provisions of paragraph a. or b. above shall determine the order of benefits as if those individuals were the parents of the child.

3.) **Active Employee or Retired or Laid-off Employee**

The Plan that covers *you* as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering *you* as a retired or laid-off employee is the Secondary Plan. The same would hold true if *you* are a *dependent* of an active employee and *you* are a *dependent* of a retired or laid-off employee. If the *other plan* does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

4.) **COBRA or State Continuation Coverage**

If *you* have coverage provided under COBRA or under a right of continuation provided by state or other federal law and *you* are also covered under another Plan, the Plan covering *you* as an employee, *member*, subscriber, or retiree or covering *you* as a *dependent* of an employee, *member*, subscriber, or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the *other plan* does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

5.) **Longer or Shorter Length of Coverage**

The Plan that covered *you* as an employee, *member*, policyholder, subscriber, or retiree longer is the Primary Plan and the Plan that covered *you* the shorter period of time is the Secondary Plan. If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

- 6.) **If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.**

Effect on the Benefits of This Plan

- A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a calendar year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan must calculate the benefits it would have paid in the absence of other healthcare coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan must credit to its plan *deductible* any amounts it would have credited to its *deductible* in the absence of other healthcare coverage.
- B. If *you* are enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel *provider*, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plan.

Right to Receive and Release Needed Information

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and *other Plans*. *We* may get the facts *we* need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and *other Plans* covering *you*. *We* need not tell, or get the consent of, any person to do this. To claim benefits under this Plan, *you* must give *us* any facts *we* need to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this plan. If it does, *we* may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. *We* will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

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

Coordination Disputes

If *you* believe that *we* have not paid a claim properly, *you* should first attempt to resolve the problem by contacting *us* at 1-877-687-1189 (TTY/TDD 1-877-941-9236) or Ambetter.BuckeyeHealthPlan.com. *You* should also refer to the *complaint* and *appeals* procedures. If *you* are still not satisfied, *you* may call the Ohio Department of Insurance for instructions on filing a consumer *complaint*. Call 1-800-686-1526, or visit the Department's website at <http://insurance.ohio.gov>.

Claims

Notice of Claim

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

Proof of Loss

We must receive written *proof of loss* within 90 days of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than one year late will not be accepted, unless *you* or *your* covered *dependent member* had no legal capacity to submit such proof during that year. If we do accept the *proof of loss* after a year, we will then process the *proof of loss* within 90 days.

How to Submit a Claim

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

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

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

To request reimbursement for a *covered service*, *you* need a copy of the itemized bill or itemized statement from *your provider*. *You* also need to submit an explanation of why *you* paid for the *covered services* along with the *member* reimbursement claim form posted at Ambetter.BuckeyeHealthPlan.com under "Member Resources".

Send all the documentation to *us* at the following address:

Ambetter from Buckeye Health Plan

Attn: Claims Department

P.O. Box 5010

Farmington, MO 63640-5010

Cooperation Provision

Each *member*, or other person acting on his or her behalf, must cooperate fully to assist *us* in determining *our* rights and obligations under the contract.

Time for Payment of Claims

Benefits will be paid within 30 days after receipt of *proof of loss*. Should we determine that additional supporting documentation is required to establish responsibility of payment, we shall pay benefits within 45 days after receipt of *proof of loss*. If we do not pay within such period, we shall pay interest at the rate of 18 percent per annum from the 30th day after receipt of such *proof of loss* to the date of late payment.

Payment of Claims

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

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

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

Foreign Claims Incurred For Emergency Care

Medical emergency care is a covered benefit while traveling for up to a maximum of 90 consecutive days. If travel extends beyond 90 consecutive days, no benefit coverage is provided for medical emergencies for the entire period of travel including the first 90 days.

Claims incurred outside of the United States for emergency care and treatment of a *member* must be submitted in English or with an English translation, at the *member's* expense, within 180 calendar days from the date of service. Foreign claims must also include the applicable medical records in English or with an English translation, at the *member's* expense to show proper *proof of loss* and evidence of any payment(s) to the *provider*.

Foreign claims must be submitted with the Member Reimbursement Medical Claim Form, along with all requested documents as detailed on the claim form. All forms and member resources are available at Ambetter.BuckeyeHealthPlan.com.

The amount of reimbursement will be based on the following:

- Member's Benefit Plan and *member* eligibility on date of service
- Member's Responsibility/Share of Cost based on date of service.
- Currency Rate at the time of completed transaction, Foreign Country currency to United States currency.

Once the health plan has reviewed all the necessary documentation and the emergency claim has been processed, a *member* Explanation of Benefits (EOB) will be mailed. The EOB will identify *member* responsibility according to the *member* benefit plan at the time of travel. If services are deemed as a true medical emergency, *member* will be issued reimbursement payment for any eligible incurred costs, minus *member* cost share obligation.

Assignment

We will reimburse a *hospital* or *healthcare provider* if:

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

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

Custodial Parent

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

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

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

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

Physical Examination

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

Personal Health Information (PHI)

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

We protect all oral, written and electronic PHI. We follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. We are required to notify you about these practices every year. This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. If you need more information or would like the complete notice, please visit <https://ambetter.BuckeyeHealthPlan.com/privacy-practices.html> or call Member Services at 1-877-687-1189 (TTY/TDD 1-877-941-9236).

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

Language

If you don't speak or understand the language in your area, you have the right to an interpreter. For language assistance, please visit: <https://ambetter.BuckeyeHealthPlan.com/language-assistance.html>.

Legal Actions

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

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

Non-Assignment

This *Contract*, including but not limited to the coverage, rights, privileges and benefits provided for under this *contract* 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 *contract* 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 *contract* is not intended to, nor does it, create or grant any rights in favor of any *third party*, including but not limited to any *hospital, provider* or *medical practitioner* providing services to you, and this *contract* shall not be construed to create any *third party* beneficiary rights.

How to Contact Us

Buckeye Health Plan

P.O. Box 5010

Farmington, MO 63640-5010

1-877-687-1189 (TTY/TDD 1-877-941-9236), fax 1-866-258-4102, twenty-four hours per day, seven days a week.

Appeals and Grievance Procedures

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

Call Member Services

Please contact *our* Member Services team at 1-877-687-1189, TDD/TTY 1-877-941-9236 if *you* have questions or concerns. *We* will attempt to answer *your* questions during initial contact, as most concerns can be resolved with one phone call.

Appeals Procedures

An Appeal is a request by the *member* or their *authorized representative* for the insurer to reconsider, reverse, or otherwise modify an *adverse benefit determination*. *You* can designate a representative –such as a family member, friend, *physician*, or attorney- to *appeal* these decisions on *your* behalf.

Filing an Appeal

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

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

Buckeye Health Plan
Appeal Department
4349 Easton Way, Suite 300
Columbus, OH 43219
Fax 1-866-258-4102 (*Appeal*)

You can also file an *appeal* via phone by contacting *us* at 1-877-687-1189, TDD/TTY 1-877-941-9236.

Processing your Appeal

After *you* file *your appeal*, *we* will notify *you* of all the information that is needed to process the *appeal* within 3 business days of receipt of the *appeal*. *You* will be informed that *you* can present any information that *you* wish for *us* to consider as part of the *appeal*. *We* will investigate the *appeal* to decide if more information is needed from *you* or *your provider*.

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

Ambetter from Buckeye Health Plan may extend *our* deadline by no more than 14 calendar days if *we* need additional information to reach a decision. *We* will inform *you* of the request's status if such an extension is necessary. If *we* do not receive the required information within the extended timeframe, *we* will make a determination based on the information *we* have. If no extension is needed, *we* will make the decision within 15 calendar days for pre- service appeals and 30 calendar days for post-service appeals, of receipt of *your appeal*.

We will notify *you* or *your authorized representative* in writing within 2 business days of the decision, not to exceed the total resolution timeframe. The notice will include an explanation of *our* decision, a reference to the criteria on which the decision was based, a list of the title and qualifications of each person participating in the review, and a description of *your* further *appeal* rights. *Your* further *appeal* rights include the right to an *external review*.

Expedited Appeal

You can file an expedited *appeal* when a requested service involves a situation that would seriously jeopardize *your* life or health or would jeopardize *your* ability to regain maximum function. This type of *appeal* must be documented with clinical information.

You may request an expedited *appeal* at any time. You may start the *appeal* by phone or in writing. You may call 1-877-687-1189, TDD/TTY 1-877-941-9236 to initiate an expedited *appeal* request.

We will make a decision about the request within 72 hours. We will notify *you* and *your authorized representative* of the result.

External Review

If *you*, or *your authorized representative*, are not satisfied with the final outcome of the Internal *Appeal*, an *external review* by an *Independent Review Organization* or by the superintendent of insurance, or both, may be requested. You, or *your authorized representative*, can request an *external review* when the *Appeal* is of *adverse benefit determinations* based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. Filing an *external review* will not affect *your* healthcare services. We want to know *your* concerns so we can improve *our* services. An *external review* decision is binding on *us*. An *external review* decision is binding on the claimant except to the extent the claimant has other remedies available under applicable federal or state law. We will pay for the costs of the *external review* performed by the independent reviewer.

All requests for an *external review* must be made within 180 days of the date of the notice of the plan's *final adverse benefit determination*. Standard requests for an *external review* must be provided in writing; requests for expedited *external reviews*, including *experimental/investigational*, may be submitted orally or electronically. When an oral or electronic request for review is made, written confirmation of the request must be submitted to the plan no later than 5 days after the initial request was made. If the superintendent or *IRO* requires additional information from *you* or *your healthcare provider*, the plan will tell *you* what is needed to make the request complete. The *IRO* assigned to review an *adverse benefit determination* shall provide written notice of its decision to either uphold or reverse the determination within thirty (30) calendar days of receipt by the health plan issuer of a request for a standard review or a standard review involving an *experimental or investigational treatment*.

You may file the request for an *external review* by contacting the plan:

Buckeye Health Plan
Appeals Unit
4349 Easton Way, Suite 300
Columbus, OH, 43219
Fax: 1-866-258-4102

You may also request an *external review* by calling 1-877-687-1189 (TTY/TDD 1-877-941-9236) or by emailing *us* at Ambetter.BuckeyeHealthPlan.com.

Urgent request for an external review

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

Non-urgent request for an external review

Unless the request is for an expedited *external review*, the plan will initiate an *external review* within 5 days after it receives *your* written request if *your* request is complete. The plan will provide *you* with notice that it has initiated the *external review* that includes:

(a) The name and contact information for the assigned *independent review organization* or the superintendent of insurance, as applicable, for the purpose of submitting additional information; and

(b) Except for when an expedited request is made, a statement that *you* may, with 10 business days after the date of receipt of the notice, submit, in writing, additional information for either the *independent review organization* or the superintendent of insurance to consider when conducting the *external review*.

If your request is not complete, the plan will notify *you* in writing and include information about what is needed to make the request complete.

If the plan denies your request for an external review on the basis that the adverse benefit determination is not eligible for an external review, the plan will notify *you*, in writing, the reasons for the denial and that *you* have a right to *appeal* the decision to the superintendent of insurance.

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

Request for external review to the Department of Insurance: If the plan denies *your* request for an *external review*, *you* may file a request for the superintendent of insurance to review the plan's decision by contacting Consumer Services Division at 1-800-686-1526 between 8:00 a.m. and 5:00 p.m., eastern standard time or by sending a written request addressed to: Consumer Services, The Ohio Department of Insurance, 50 West Town St., Suite 300, Columbus, Ohio 43215. Information about *external reviews* is also available on the Department's website: www.insurance.ohio.gov.

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

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

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

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

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

The request for an expedited *external review* under this provision may be requested orally or electronically. For Expedited/Urgent requests, *your healthcare provider* can orally make the request on *your* behalf.

If the plan reverses its decision: If the plan decides to reverse its adverse determination before or during the

external review, the plan will notify *you*, the *IRO*, and the superintendent of insurance within one business day of the decision.

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

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

Review by the Department of Insurance: If the plan has made an *adverse benefit determination* based on a contractual issue (e.g. whether a service or services are covered under *your contract* of insurance), *you* may request an *external review* by the department of insurance.

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

Grievances

A *grievance* or *complaint* is an expression of dissatisfaction regarding *our* products or services. *You* or *your* designee may submit a *grievance* verbally or in writing. A *grievance* may be filed for issues including quality of care, *physician* behavior, waiting time for services, and involuntary disenrollment. *You* have up to 180 calendar days to file a *grievance*. The 180 calendar days start on the date of the situation *you* are not satisfied with. Depending on the nature of the *grievance* and whether or not a response is requested, *we* will respond verbally and/or in writing within thirty (30) business days following receipt of the *grievance*, or should a *member's* medical condition necessitate an expedited review and decision within 48 hours.

Filing a Grievance

You or *your authorized representative* may file a *grievance* by calling *our* Member Services Team at 1-877-687-1189 (TTY/TDD 1-877-941-9236) or in writing by mailing or faxing *your grievance* to:

Buckeye Health Plan
Appeals Unit
4349 Easton Way, Suite 300
Columbus, OH, 43219
Fax 1-877-865-0992

If filing a written *grievance*, please include:

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

Process and Resolution Timeframes

We will acknowledge *your grievance* by sending *you* a letter within 3 business days of receipt of *your grievance*. *Grievances* will be promptly investigated, and will be resolved within 30 calendar days of receipt. *We* will notify *you* in writing within 2 business days of the decision. The time period may be extended for an additional 14 calendar days, making the maximum time for the entire *grievance* process 44 calendar days if *we* provide *you* or *your authorized representative*, if applicable, written notification of the following within 30 calendar days:

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

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

The written response will state the reason for *our* decision, and inform the *member* of the right to pursue a further review, and explain the procedures for initiating such review. *Grievances* will be considered when measuring the quality and effectiveness of *our* products and services.

Appeals and Grievances filing, External Review, and key communication timelines

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard Grievance	180 Calendar Days	3 Business Days	30 Calendar Days	14 Calendar Days
Expedited Grievance	180 Calendar Days	N/A	48 Hours	N/A
Standard Pre-Service Appeal	180 Calendar Days	3 Business Days	15 Calendar Days	14 Calendar Days
Expedited Pre-Service Appeal	180 Calendar Days	N/A	72 Hours	N/A
Standard Post-Service Appeal	180 Calendar Days	3 Business Days	30 Calendar Days	14 Calendar Days
External Review	180 Calendar Days	N/A	30 Calendar Days	N/A
Expedited External Review	180 Calendar Days	N/A	72 Hours	N/A

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

General Provisions

Entire Contract

This *contract*, with the application, amendments, and *Schedule of Benefits* is the entire *contract* between *you* and *us*. No agent may:

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

Non-Waiver

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

Rescissions

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

1. The misrepresented fact is contained in a written application, including amendments, signed by a *member*;
2. A copy of the application, and any amendments, has been furnished to the *member(s)*, or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *member*. A *member's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. "Rescind" has a retroactive effect and means the coverage was never in effect.
4. The *member* must be provided at least 30 calendar days' notice before rescinding coverage.

Repayment for Fraud, Misrepresentation, or False Information

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

Conformity with State Laws

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

Hold Harmless

Buckeye Health Plan is not a *member* of any guaranty fund, and in the event that *we* become insolvent, *member* is protected only to the extent that the hold harmless provision under 1751.13 applies to those healthcare services rendered.

In addition, in the event *we* become insolvent, the *member* may be financially responsible for healthcare services rendered by a *provider* or healthcare facility that is not under *contract* with *us*. However, the *member* is protected only to the extent that the hold harmless provision under 1751.13 applies to those healthcare services rendered.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Buckeye Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Buckeye Health Plan 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-877-687-1189 (TTY/TDD 1-877-941-9236)。
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Buckeye Health Plan hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-687-1189 (TTY/TDD 1-877-941-9236) an.
Arabic:	إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from Buckeye Health Plan، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Pennsylvania Dutch:	Vann du, adda ebbah's du am helfa bisht, ennichi questions hott veyyich Ambetter from Buckeye Health Plan, dann hosht du's recht fa hilf greeya adda may aus finna diveyya in dei shprohch un's kosht nix. Fa shvetza mitt ebbah diveyya, kaw! 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Buckeye Health Plan вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-877-687-1189 (TTY/TDD 1-877-941-9236).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Buckeye Health Plan, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Buckeye Health Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Cushite:	Yoo sii ykn namaa gargaaraa jirtuu wa'ee Ambetter from Buckeye Health Plan gaaffi qabaatan ta'ee gargaarsaa fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana wajjin dubadhuu, 1-877-687-1189 irra bilbilli (TTY/TDD 1-877-941-9236).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Buckeye Health Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-687-1189 (TTY/TDD 1-877-941-9236)로 전화하십시오.
Italian:	Se lei, o una persona che lei sta aiutando, avesse domande su Ambetter from Buckeye Health Plan, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l'1-877-687-1189 (TTY/TDD 1-877-941-9236).
Japanese:	Ambetter from Buckeye Health Plan について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-877-687-1189 (TTY/TDD 1-877-941-9236)までお電話ください。
Dutch:	Als u of iemand die u helpt vragen heeft over Ambetter from Buckeye Health Plan, hebt u recht op gratis hulp en informatie in uw taal. Bel 1-877-687-1189 (TTY/TDD (teksttelefoon) 1-877-941-9236) om met een tolk te spreken.
Ukrainian:	В разі виникнення у вас або особи, якій ви допомагаєте, будь-яких запитань щодо програми страхування Ambetter from Buckeye Health Plan ви маєте право отримати безкоштовну допомогу та інформацію на своїй рідній мові. Щоб поговорити з перекладачем, зателефонуйте за номером 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Romanian:	Dacă dvs. sau o persoană pe care o asistați are întrebări despre Ambetter from Buckeye Health Plan, aveți dreptul să obțineți asistență și informații în limba dvs. în mod gratuit. Pentru a vorbi cu un interpret, apălați 1-877-687-1189 (TTY/TDD 1-877-941-9236).

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Statement of Non-Discrimination

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

Ambetter from Buckeye Health Plan:

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

If *you* need these services, contact Ambetter from Buckeye Health Plan at 1-877-687-1189 (TTY/TDD 1-877-941-9236).

If *you* believe that Ambetter from Buckeye Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, *you* can file a *grievance* with: Buckeye Health Plan at the Appeals Unit, 4349 Easton Way, Suite 300, Columbus, OH 43219, 1-877-687-1189 (TTY/TDD 1-877-941-9236), Fax 1-866-719-5404. *You* can file a *grievance* by mail, fax, or email. If *you* need help filing a *grievance*, Ambetter from Buckeye Health Plan is available to help *you*. *You* can also file a civil rights *complaint* with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights *Complaint* Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

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