There are two different versions of this Evidence of Coverage. The first Evidence of Coverage is for the On-Exchange plans. The second Evidence of Coverage is for the Mirrored Off-Exchange plans.

The 2022 Evidence of Coverage, beginning on Page 2, covers the On-Exchange plans.

The 2022 Evidence of Coverage, beginning on Page 107, covers the Mirrored Off-Exchange plans.

2022 Evidence of Coverage

https://www.louisianahealthconnect.com/

Member Services: 1-866-595-8133 (TTY/TDD 711)
Log on to: https://www.louisianahealthconnect.com/

Ambetter from Louisiana Healthcare Connections

Home Office: 8585 Archives Avenue, Suite 310, Baton Rouge, LA 70809

Major Medical Expense Insurance Policy

In this *policy,* the terms *"you"*, *"your",* or *"yours"* will refer to the *member* or any *dependents* named on the *Schedule of Benefits*. The terms *"we," "our,"* or *"us"* will refer to **Louisiana Healthcare Connections** or **Ambetter from Louisiana Healthcare Connections**.

AGREEMENT AND CONSIDERATION

This document along with the corresponding *Schedule of Benefits* is *your* contract and 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 health care benefits to *you*, the *member*, for *covered services* as outlined in this *policy*. Benefits are subject to *policy* definitions, provisions, limitations, and exclusions.

GUARANTEED RENEWABLE

Guaranteed renewable means that this contract will renew each year on the anniversary date unless terminated earlier in accordance with *policy* terms. *You* may keep this *policy* in force by timely payment of the required premiums. However, *we* may decide not to renew the *policy* as of the renewal date if: (1) *we* decide not to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where *you* then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *policy* benefits.

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

At least 60 days' notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *policy* or a change in a *member's* health. While this *policy* is in force, *we* will not restrict coverage already in force. If *we* discontinue offering and decide not to renew all polices issued on this form, with the same type and level of benefits, for all residents of the state where *you* reside, *we* will provide a written notice to *you* at least 90 days prior to the date that *we* discontinue coverage.

This *policy* contains *prior authorization* requirements. *You* may be required to obtain a referral from a *primary care physician* in order to receive care from a *specialist provider*. Benefits may be reduced or not covered if the requirements are not met. Please refer to the *Schedule of Benefits* and the *Prior Authorization* section.

This policy takes effect at 12:01 a.m. of the date on which the *member*'s coverage begins and terminates at 11:59 pm on the last day of the month for which premiums were paid and the date that the *member*'s coverage ends.

NOTICE: HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTH CARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR COPAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES. SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF- NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT OUR WEBSITE

HTTPS://WWW.LOUISIANAHEALTHCONNECT.COM/ OR CALLING US AT 1-866-595-8133 (TTY/TDD 711).

NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

TEN DAY RIGHT TO RETURN POLICY

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

Louisiana Healthcare Connections

Jamie Schlottman
CEO and Plan President

TABLE OF CONTENTS

Introduction

Welcome to Ambetter from Louisiana Healthcare Connections! This *policy* has been prepared by *us* to help explain *your* coverage. Please refer to this *policy* whenever *you* require medical services.
It describes:

- How to access medical care.
- What health services are covered by *us*.
- What portion of the health care costs *you* will be required to pay.

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

This *policy* should be read in its entirety. Since many of the provisions are interrelated, *you* should read the entire *policy* to get a full understanding of *your* coverage. Many words used in the *policy* have special meanings: these words are *italicized* and are defined for *you* in the Definitions section. This *policy* also contains exclusions, so please be sure to read this *policy* carefully.

How to Contact Us
Ambetter from Louisiana Healthcare Connections
8585 Archives Avenue, Suite 310
Baton Rouge, LA 70809

Normal Business Hours of Operation 7:00 a.m. to 7:00 p.m.

Member Services	1-866-595-8133
TDD/TTY line	711
Fax	1-866-768-9374
Emergency	**911**

24/7 Nurse Advice Line 1-866-595-8133 or for the hearing impaired (TDD/TTY 711)

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

Our interpreter services are provided at no cost to *you*. *We* have representatives that speak Spanish and medical interpreters to assist with other languages. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpreter services, please call Member Services at 1-866-595-8133 (TTY/TDD 711).

Member Rights and Responsibilities

We are committed to:

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

If *you* have difficulty locating a primary care *provider*, specialist, *hospital* or other contracted *provider* please contact *us* so that *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 making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or *your* legally *authorized representative*. *You* will be informed of *your* care options.
2. Know who is approving and who is 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 physician* about what might be wrong (to the level known), treatment and any known likely results. *Your primary care physician* can tell *you* about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for *your approval* for treatment unless there is an *emergency* and *your* life and health are in serious danger.
8. Make recommendations regarding *member's* rights, responsibilities, and policies.
9. Voice *complaints* or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(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 physician* assignment, *providers*, advance directive information, referrals and *authorizations*, benefit denials, *member* rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such notices shall include:

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

13. A current list of *network providers*.
14. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
15. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin, or religion.
16. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
17. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
18. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *primary care physician*'s instructions are not followed. *You* should discuss all concerns about treatment with *your primary care physician*. *Your primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
19. Select *your primary care physician* within the *network*. *You* also have the right to change *your primary care physician* or request information on *network providers* close to *your* home or work.
20. Know the name and job title of people giving *you* care. *You* also have the right to know which *physician* is *your primary care physician*.
21. An interpreter when *you* do not speak or understand the language of the area.
22. A second opinion by a *network physician*, at no cost to *you*, if *you* believe *your network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
23. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it.
24. Advance directives are forms *you* can complete to protect *your* rights for medical care. It can help *your primary care physician* 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 *policy* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of *your physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us. You* need to know the proper use of *covered services*.
5. Show *your* ID card and keep scheduled appointments with *your physician*, and call the *physician's* office during office hours whenever possible if *you* have a delay or cancellation.
6. Know the name of *your* assigned *primary care physician*. *You* should establish a relationship with *your physician*. *You* may change *your primary care physician* 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* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.

9. Supply, to the extent possible, information that *we* or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with *your primary care physician* 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 physician*.
14. When *you* enroll in this coverage, give all information about any other medical coverage *you* have. If, at any time, *you* get other medical coverage besides this coverage, *you* must tell *us*.
15. Pay *your* monthly premiums on time and pay all *deductible amounts, copayment amounts*, or *cost sharing percentages* at the time of service.
16. Inform the entity in which *you* enrolled for this *policy* if *you* have any changes to *your* name, address, or family members covered under this *policy* within 60 days from the date of the event.
17. 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*.

Important Information

Provider Directory
A listing of *network providers* is available online at https://findaprovider.louisianahealthconnect.com/location/. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* with *your* healthcare services. *You* may find any of *our network providers* by completing the "Find a Provider" function on *our* website and selecting the Ambetter Network. There *you* will have the ability to narrow *your* search by *provider* specialty, zip code, gender, language spoken and whether or not they are currently accepting new patients. *Your* search will produce a list of *providers* based on *your* search criteria and will give *you* other information such as name, address, phone number, office hours, specialty and board certifications.

At any time, *you* can request a copy of the provider directory at no charge by calling Member Services at 1-866-595-8133 (TTY/TDD 711). In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. We* can also help *you* pick a *primary care physician* (*PCP*). *We* can make *your* choice of *primary care physician* effective on the next business day.

Call the *primary care physician*'s office if *you* want to make an appointment. If *you* need help, call Member Services at 1-866-595-8133 (TTY/TDD 711). *We* will help *you* make the appointment.

Member ID Card
When *you* enroll, *we* will mail *you* a *member* ID card after *we* receive *your* completed enrollment material and *you* have paid *your* initial premium payment. This card is proof that *you* are enrolled in the Ambetter plan. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under the *policy*. The ID card will show *your* name, *member* ID number, the phone numbers for Member Services, pharmacy and 24/7 Nurse Advice Line and *copayment amounts* required at the time of service. If *you* do not get *your* ID card within a few weeks after *you* enroll, please call Member Services at 1-866-595-8133 (TTY/TDD 711). *We* will send *you* another card.

The ID card will show *your* name, member ID#, and *copayment amounts* required at the time of service. If *you* do not get *your* ID card within a few weeks after *you* enroll, please call Member Services at 1-866-595-8133 (TTY/TDD 711). *We* will send *you* another card.

Website
Our website helps *you* get the answers to 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 https://www.louisianahealthconnect.com/. It also gives *you* information on *your* benefits and services such as:

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

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.

Quality Improvement

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

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

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

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

Definitions

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

Wherever used in this *policy*:

Acute rehabilitation means *rehabilitation* for patients who will benefit from an intensive, multidisciplinary rehabilitation program. Patients normally received 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*.

Advance 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 premium tax credits* can be used right away to lower *your* monthly premium costs. If *you* qualify, *you* may choose how much *advance premium tax credit* to apply to *your* premiums each month, up to a maximum amount. If the amount of *advance premium tax credits you* receive for the year is less than the total tax credit you are due, you will get the difference as a refundable credit when *you* file *your* federal income tax return. If *your advance premium tax credits* for the year are more than the total amount of *your* premium tax credit, *you* must repay the excess *advance premium tax credit* with *your* tax return.

Adverse determination means any of the following:

(a) A determination by a health insurance issuer or its designee *utilization review* organization that, based upon the information provided, a request for a benefit under the health insurance issuer's health benefit plan upon application of any *utilization review* technique does not meet the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.

(b) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health insurance issuer or its designee *utilization review* organization of a *covered person's* eligibility to participate in the health insurance issuer's health benefit plan.

(c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit under a health benefit plan.

(d) A *rescission of coverage* determination.

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

Allowed amount (also see **"*Eligible Service Expense*"**) means the maximum amount we will pay a *provider* for a *covered service*. When a *covered service* is received from a *network provider*, the *allowed amount* is the amount the *provider* agreed to accept from *us* as payment for that particular service. In all cases, the *allowed amount* will be subject to *cost sharing* (e.g., *deductible*, *coinsurance* and *copayment*) per the *member's* benefits. This amount excludes any payments made to the *provider* by *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. However, *you* will not be responsible for *balance billing* for unanticipated 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 *non-network facility* for *emergency services* or air ambulance services. This is known as *balance billing* – 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.

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

Applied behavioral analysis or ***ABA*** means the application 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 *medically necessity* or appropriateness of care for a *member* by the *member's PCP* or *provider*. Authorizations are not a guarantee of payment.

Authorized representative means any of the following:

(a) A person to whom a *covered person* has given express written consent to represent the *covered person*. It may also include the *covered person's* treating provider if the *covered person* appoints the provider as his *authorized representative* and the provider waives in writing any right to payment from the *covered person* other than any applicable *copayment* or other *coinsurance* amount. In the event that the service is determined not to be *medically necessary*, and the *covered person* or his *authorized representatives*, except for the *covered person's* treating health care professional, thereafter requests the services, nothing shall prohibit the provider from charging usual and customary charges for all non-*medically necessary* services provided.

(b) A person *authorized* by law to provide substituted consent for a *covered person*.

(c) An *immediate family* member of the *covered person* or the *covered person's* treating health care professional when the *covered person* is unable to provide consent.

(d) In the case of an urgent care request, a health care professional with knowledge of the *covered person's* medical condition.

Autism spectrum disorder means as defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* 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 ever 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.

Beneficiary means a person designated by a participant, or by the terms of a health insurance benefit plan, who is or may become entitled to a benefit under the plan.

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

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

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

Care management 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 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 *listed transplants* or other services such as cancer, bariatric, or infertility; and
2. Has agreed with *us* or an entity designated by *us* to meet quality of care criteria on a cost efficient basis. The fact that a *hospital* is a *network provider* does not mean it is a *Center of Excellence.*

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

Cleft Lip and Cleft Palate Services means preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.

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, *physician* prescribed rest during the period of *pregnancy*, morning sickness, and conditions of comparable severity associated with management of a difficult *pregnancy*, and not constituting a medically classifiable distinct complication of *pregnancy*.
2. An *emergency* caesarean section or a *non-elective caesarean section*.

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.

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

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

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

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

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

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

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

Credible coverage means coverage of an individual under (a) A group health plan; (b) Health insurance coverage; (c) Medicare coverage; (d) Medicaid; (e) Medical Insurance coverage under the General Military Law; (f) A medical care program of the Indian Health Service of a tribal organization; (g) A state health benefits risk pool; (h) A health plan offered for federal employees; (i) A public health plan; or (j) A health benefit plan provided to members of the Peace Corps. Such term does not include coverage consisting solely of coverage of excepted benefits.

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

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

1. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding, and use of toilet;
2. Preparation and administration of special diets;

3. Supervision of the administration of medication by a caregiver;
4. Supervision of self-administration of medication; or
5. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, sanatoria care, educational care, or recreational care.

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

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

If *you* are a covered *member* in a family of two or more members, *you* will satisfy *your deductible amount* when:
1. *You* satisfy *your* individual *deductible amount*; or
2. *Your* family satisfies the family *deductible amount* for the *calendar year*.

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

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

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

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

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

Eligible child means the child or grandchild of a *covered person*, if that child is less than 26 years of age. As used in this definition, "child" means:
1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption;
4. A child for whom legal guardianship has been awarded to *you* or *your spouse*; or
5. A stepchild;
6. A grandchild residing with *you,* provided *you* have been granted legal custody or provisional custody by mandate of the grandchild; or
7. An unmarried child who is placed in the home of an insured following execution of an act of voluntary surrender in favor of *you* or *your* legal representative, for whom the date after which the act of voluntary surrender becomes irrevocable has passed.

It is *your* responsibility to notify the Health Insurance Marketplace if *your* child or grandchild ceases to be an *eligible child*. *You* must reimburse *us* for any benefits that *we* provide or pay for a child or grandchild at a time when the child or grandchild 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 Louisiana 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, if any, that has been mutually agreed upon by *us* and the *provider* as payment in full. However, if the *provider* has not agreed to accept a negotiated fee with *us* as payment in full, the *eligible service expense* is the median contracted amount paid to *network providers* for the same *covered service*. *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.
    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. Member *cost share* will be calculated from the recognized amount based upon 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 an anesthesiologist, pathologist or a radiologist 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. However, if the *provider* has not agreed to accept a negotiated fee with *us* as payment in full, the *eligible service expense* is the median contracted amount paid to *network providers* for the same *covered service*. *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* professional *provider,* excluding those providers outlined in 2(c) above, 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* is reimbursement as determined by *us* and as required by applicable law. Unless you receive and sign the necessary written notice and consent document under federal 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. Member *cost share* will be calculated from the recognized amount based upon applicable law. If *you* are balance billed in these situations, please contact Member Services *immediately* at the number listed on the back of *your* ID card.
    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: (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. In addition to applicable *cost sharing*, *you* may *be balance billed* for these services.

Emergency medical condition is a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy;
b. Serious impairment to bodily function;
c. Serious dysfunction of any bodily organ or part.

Emergency medical services are those medical services necessary to screen, evaluate, and stabilize an *emergency medical condition*.

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

Enrollee means an individual who is enrolled in a health maintenance organization.

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

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

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

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

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("*FDA*") regulation, regardless of whether the trial is subject to *USFDA* oversight.
2. An *unproven service.*
3. Subject to *FDA approval*, and:
    a. It does not have *FDA* approval;
    b. It has *FDA approval* only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has *FDA approval*, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *FDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;

ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
iii. Not an *unproven service*; or

d. It has *FDA approval*, but is being used for a use, or to treat a condition, that is not listed on the Premarket *Approval* issued by the *FDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*

4. *Experimental* or *investigational treatment* according to the *provider's* research protocols.

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

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 *generally accepted standards of medical practice* for that condition.

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

Final adverse determination means an *adverse determination*, including medical judgment, involving a covered benefit that has been upheld by a health insurance issuer, or its designee *utilization review* organization, at the completion of the health insurance issuer's internal claims and appeals process procedures provided pursuant to R.S. 22:2401.

Follow-up care is not considered emergency care. Benefits are provided for treatment of *emergency medical conditions* and *emergency* screening and stabilization services without *prior authorization*. Benefits for *emergency* care include facility costs and *physician* services, and supplies and *prescription drugs* charged by that facility. *You* must notify *us* or verify that *your physician* has notified *us* of *your* admission to a *hospital* within 48 hours or as soon as possible within a reasonable period of time. When *we* are contacted, *you* will be notified whether the *inpatient* setting is appropriate, and if appropriate, the number of days considered *medically necessary*. By contacting *us*, *you* may avoid financial responsibility for any *inpatient* care that is determined to be not *medically necessary* under *your* Plan. If *your provider* does not contract with *us*, *you* will be financially responsible for any care *we* determine is not *medically necessary*. Care and treatment provided once *you* are *medically stabilized* is no longer considered *emergency* care. Continuation of care from a non-participating *provider* beyond that needed to evaluate or stabilize *your* condition in an *emergency* will be covered as a non-*network* service unless *we authorize* the continuation of care and it is *medically necessary*.

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

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

recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

Grievance means, in a health insurance issuer's internal claims and appeals process, a written *complaint* or oral *complaint*, if the *complaint* involves an urgent care request submitted by or on behalf of a *covered person* regarding any of the following:

(a) Availability, delivery, or quality of health care services, including a *complaint* regarding an *adverse determination* made pursuant to *utilization review*.
(b) Claims payment, handling, or reimbursement for health care services.
(c) Matters pertaining to the contractual relationship between a *covered person* and a health insurance issuer.

Habilitation or ***habilitation services*** means health care services that help *you* 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* or outpatient settings.

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

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

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

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

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

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

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

Hospice means services designed for and provided to *members* who are not expected to live for more than 6 months, as certified by an Ambetter *physician*. Ambetter works with certified *hospice* programs licensed by the state to minimize patient discomfort and address the special physical, psychological, and social needs of *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 place for the aged, drug addicts, alcoholics, or runaways; a facility for wilderness or outdoor programs; or a similar establishment.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *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 be deemed not to be confined in a *hospital* for purposes of this *policy*.

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

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

Immediately means as expeditiously as the medical situation of the *covered person* requires but in no event longer than one day for expedited reviews or one business day for standard reviews.

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

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

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

Life-threatening illness means a severe, serious, or acute condition for which death is probable.

Listed transplant means one of the following procedures:
1. Heart transplants.
2. Lung transplants.
3. Heart/lung transplants.
4. Kidney transplants.
5. Liver transplants.
6. Bone marrow transplants for the following conditions, including, but not limited to:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. *BMT* for Chronic Myelogenous Leukemia.
    f. *ABMT* for Testicular Cancer.
    g. *BMT* for Severe Combined Immunodeficiency.
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
    i. *BMT* for Myelodysplastic Syndrome.
    j. *BMT* for Wiskott-Aldrich Syndrome.
    k. *BMT* for Thalassemia Major.
    l. *BMT* or *ABMT* for Multiple Myeloma.

m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
n. *BMT* for Fanconi's anemia.
o. *BMT* for malignant histiocytic disorders.
p. *BMT* for juvenile myelomonocytic leukaemia (JMML).

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

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

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

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

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

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

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

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

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

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

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

Medical practitioner includes but is not limited to a *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.

Medically necessary means *our* decision as to whether any medical service, item, supply 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. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental* or *investigational*;
6. Is provided in the most cost effective care facility or setting;
7. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; and
8. When specifically applied to a *hospital* confinement, it means that the diagnosis and treatment of *your* medical symptoms or conditions cannot be safely provided as an outpatient.

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

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

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

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

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

Necessary medical supplies means medical supplies that are:

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

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

Network means a group of *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* health services even if provided by a *non-network provider*.

Network provider means any person or entity that has entered into a contract with Ambetter from Louisiana Healthcare Connections 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*.

Newly Born means infants from the time of birth until age one month or until such time as the infant is well enough to be discharged from a *hospital* or neonatal special care unit to his home, whichever period is longer.

Non-elective caesarean section means:

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

Non-network provider means a *medical practitioner, 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 not *covered*, except as specifically stated in this *policy*.

Orthotic device means a *medically necessary* custom fabricated brace or support that is designed as a component of a *prosthetic device*.

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

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

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

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

Period of extended loss means a period of consecutive days:

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

Physician 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.

Placement or ***being placed***, for adoption, in connection with any *placement* for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's *placement* with such person terminates upon the termination of such legal obligation.

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

Policy Year is the 12-month *calendar year* beginning at 12:00 a.m. on January 1 and ending at 11:59 p.m. on December 31.

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.

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

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

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

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

Primary care physician or ***PCP*** means a *physician* who is a family practitioner, general practitioner, pediatrician, or internist.

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

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

Prosthetic device means an artificial leg or arm.

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

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

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

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

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

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

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

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

Rehabilitation licensed practitioner means, but is not limited to, a *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 coverage means a cancellation or discontinuance of coverage that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:

1. The cancellation or discontinuance of coverage has only a prospective effect; or

2. The cancellation or discontinuance of coverage 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 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 acute condition means a disease or condition requiring complex ongoing care which the *Member* is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits.

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 parishes, where *we* have been authorized by the State of Louisiana 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* health care services and supplies. *You* can receive precise *service area* boundaries from *our* website or Member Services.

Social determinants of health means 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 physician means a *physician* who is not a *primary care physician.*

Specialist provider means 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.

Spouse means *your* lawful wife or husband.

Subscriber means the person who is responsible for payment to a health maintenance organization or whose employment or other status, except for family dependence, is the basis for eligibility for enrollment in the health maintenance organization.

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

Surgery or ***surgical procedure*** means:
1. An invasive diagnostic procedure; or
2. The treatment of a *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.

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

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

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

Telemedicine services means health care services delivered by use of interactive audio, video, or other electronic media, including the following:
1. Medical exams and consultations; and,
2. *Behavioral health*, including *substance abuse* evaluations and treatment.

The term does not include the delivery of health care services by use of the following:
1. A telephone transmitter for trans-telephonic monitoring; or,
2. A telephone or any other means of communication for the consultation from one (1) *provider* to another *provider*.

Temporarily Medically Disabled Mother means a woman who has recently given birth and whose *physician* has advised that normal travel would be hazardous to her health.

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 *policy* was completed by the *member*, including all tobacco and nicotine products, e-cigarettes or vaping devices, but excluding religious and ceremonial uses of tobacco.

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

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

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

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

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

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

Dependent Member Coverage

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

1. The date *you* became covered under this *policy*;
2. The date of marriage to add a *spouse*;
3. The date of an eligible newborn's birth; or
4. The date that an adopted child is placed with *you* or *your spouse* for the purposes of adoption or *you* or *your spouse* assumes total or partial financial support of the child.

Effective Date for Initial Dependent Members
The *effective date* for *your* initial *dependent members,* if any, is shown on the *Schedule of Benefits*. Only *dependent members* included in the application for this *policy* will be covered on *your effective date*.

Dependent Medical Leave of Absence
Coverage will continue for a *dependent member* college student who takes a medical leave of absence or reduces his or her course load to part-time status because of a catastrophic *illness* or *injury*. Continuation of coverage for such a *dependent member* college student will automatically terminate 12 months after notice of the *illness* or *injury* or until coverage would have otherwise lapsed pursuant to the terms and conditions of this *contract*, whichever comes first, provided the need for part-time status or medical leave of absence is supported by a clinical certification of need from a *physician* licensed to practice medicine in all its branches.

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

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

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

The child will be covered for *loss* due to *injury* and *illness* including *medically 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 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 Marketplace within 60 days of the birth or *placement* and b) any additional premium required for the addition of the child within 90 days of the date of *placement.*

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

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

Ongoing Eligibility

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

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *policy*;
2. The date a *member's* employer and a *member* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes;
3. The primary *member* residing outside the *service area* or moving permanently outside the *service area* of this plan;
4. The date *we* receive a request from *you* to terminate this contract, or any later date stated in *your* request, or if *you* are enrolled through the Marketplace, the date of termination that the Marketplace provides *us* upon *your* request of cancellation to the Marketplace;
5. 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;
6. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact (e.g. the date that a *member* accepts any direct or indirect contributions or reimbursement by or on behalf of an employer, for any portion of the premium for coverage under this contract); or
7. The date of a *member's* death.

If *you* have material modifications (examples include a change in life event such as marriage, death, or other change in family status), or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace (Marketplace) at www.healthcare.gov or 1-800-318-2596. If you enrolled through Ambetter, you can contact Member Services at 1-866-595-8133 (TTY/TDD 711).

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

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

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

You must furnish *us* with periodic proof of continuing incapacity and dependency within thirty-one (31) days of the child's 26th birthday. *We* may require subsequent proof once a year after the initial two-year period following the child's 26th birthday.

Open Enrollment
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.

Special and Limited 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 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 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 Louisiana Healthcare Connections, please contact Member Services at 1-866-595-8133 (TYY/TDD 711) 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. A *subscriber* may enroll an unborn natural child prior to birth, however, coverage will not be effective until the date of birth.

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.

Premiums

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

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

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

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

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

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

1. Ryan White HIV/AIDS program under Title XXVI of the Public Health Service Act;
2. Indian tribes, tribal organizations, or urban Indian organizations;
3. State and Federal government programs; or
4. Family members.

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

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

Misstatement of Age
If a *member's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

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

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

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

Prior Authorization

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

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

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

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

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

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

1. At least 5 days prior to an elective admission as an *inpatient* in a *hospital*, *extended care* or *rehabilitation facility*, or *hospice* facility.
2. At least 30 days prior to the initial evaluation for organ transplant services.
3. At least 30 days prior to receiving clinical trial services.
4. Within 24 hours of an admission for *inpatient* mental health or *substance abuse* treatment.
5. At least 5 days prior to the start of *home health care*.

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

1. For immediate request situations, within 1 business day, when the lack of treatment may result in an emergency room visit or *emergency* admission.
2. For urgent concurrent reviews within 24 hours of receipt of the request.
3. For urgent *pre-service* reviews, within 72 hours from date of receipt of request.
4. For non-urgent *pre-service* reviews within 5 days, but no longer than 15 days, of receipt of the request.
5. For post-service or retrospective reviews, within 30 calendar days of receipt of the request.

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

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

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

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

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

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

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

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

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

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 *prior authorization* for *you* to obtain services from a *non-network provider* at no greater cost to *you* than if *you* went to a *network provider*. If *covered services* are not available from a *network provider, you* or *your* primary care provider must request *prior authorization* from *us* before *you* may receive services from a *non-network provider*. Otherwise, *you* will be responsible for all charges incurred.

Hospital Based Providers
When receiving care at an Ambetter participating *hospital* it is possible that some *hospital*-based *providers* (for example, anesthesiologists, radiologists, pathologists) may not be under contract with Ambetter as participating *providers*. *We* encourage *you* to inquire about the *providers* who will be treating *you* before *you* begin *your* treatment, so *you* can understand their participation status with Ambetter. *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.

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

Cost Sharing Features

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

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

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

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

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

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

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

The amount provided or payable will be subject to:

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

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

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

Access to Care

Primary Care Provider
In order to obtain benefits, *you* must designate a *network primary care physician* 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 physician* who is accepting new patients from any of the following *provider* types:

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

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

You may obtain a list of *network primary care providers* at *our* website and using the "Find a Provider" function or by calling the telephone number shown on the front page of this contract. *You* should get to know *your PCP* and establish a healthy relationship with them. *Your PCP* will:

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

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

Your network primary care physician 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 physician* for obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist. You have direct access to qualified obstetric and gynecological care.

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 1-866-595-8133 (TTY/TDD 711). A licensed nurse is always available and ready to answer *your* health questions. In an emergency, call 911 or head straight to the nearest emergency room.

Changing Your Primary Care Physician (PCP)
You may change *your network primary care physician* for any reason, but not more frequently than once a month, by submitting a written request, online at our website at https://www.louisianahealthconnect.com/, or by contacting *our* office at the number shown on *your* identification card. The change to *your network primary care physician* of record will be effective no later than 30 days from the date *we* receive *your* request.

Referral Required For Maximum Benefits
You do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* may be required to obtain a referral from *your network primary care physician* for benefits to be payable under *your policy* or benefits payable under this *policy* may be reduced. Please refer to the *Schedule of Benefits*.

Network Availability
Your *network* is subject to change. The most current *network* may be found online at our website or by contacting *us* at the number shown on *your* identification card. A *network* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, please contact Member Services prior to moving. Note that services from *non-network providers* are not *covered services* under this agreement but you may have the opportunity to disenroll from coverage under this contract and enroll in a different health plan with a *network* in that area. If *you* receive non-*emergency services* from *non-network providers*, benefits will be calculated in accordance with the terms of this contract for *non-network providers*.

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

Non-Emergency Services
If *you* are traveling outside of the Louisiana *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 Louisiana by searching the relevant state in *our* provider directory at 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.

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 to the nearest emergency room. Be sure to a call *us* and report *your emergency* within one business day. *You* do not need *prior approval* for *emergency* care services. Payments of claims for *emergency medical services* rendered by a *non-network provider* are not made directly to *you*.

Pre-admission Testing
Benefits will be provided for the *outpatient facility* charge and associated professional fees for diagnostic services rendered within 72 hours of a scheduled procedure performed at an *inpatient* or *outpatient facility*.

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*.

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*. *We* 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*.

Major Medical Expense Benefits

Ambulance Service Benefits

Prior authorization is not required for *emergency* ambulance transportation.

Note: non-emergency ambulance transportation requires *prior authorization*.

Covered service expenses will include ambulance services for local transportation:

1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury* in cases of *emergency*.
2. To the nearest available *hospital* or neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.
3. For the *temporarily medically disabled mother* of an ill *newly born* infant when accompanying the ill *newly born* infant to the nearest *hospital* or neonatal special care unit, upon recommendation by the mother's attending *physician* of her need for professional ambulance service.
4. Transportation between *hospitals* or between a *hospital* and a skilled nursing or *rehabilitation facility* when *authorized* by *us*.

Exclusions:

No benefits will be paid for:

1. Expenses incurred for *ambulance services* covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-*emergency* air ambulance.
3. *Ambulance services* provided for a *member's* comfort or convenience.
4. Non-*emergency* transportation excluding ambulances (for example, transport-van, taxi).

Air Ambulance Service Benefits

Covered service expenses will include *ambulance services* for ground, water, 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 available *hospital* or neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.
3. For the *temporarily medically disabled mother* of an ill *newly born* infant when accompanying the ill *newly born* infant to the nearest *hospital* or neonatal special care unit, upon recommendation by the mother's attending *physician* of her need for professional ambulance service.
4. Transportation between *hospitals* or between a *hospital* and a skilled nursing or *rehabilitation facility* when *authorized* by *us*.

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.

Benefits for air *ambulance services* are limited to:

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

Exclusions:

No benefits will be paid for:

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

Ambulatory Patient Services

Covered Service and supply expenses for ambulatory patient services will include *Medically Necessary* services delivered in settings other than a *Hospital* or *Rehabilitation* or *Extended Care Facility*, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat *illness* or *injury*. Such services include in-*network*:

1. *Hospice* and Home Healthcare, including skilled nursing care as an alternative to hospitalization;
2. Provider office visits and treatments, and associated supplies and services, including therapeutic injections and related supplies;
3. *Urgent Care Center* visits, including Provider services, Facility costs and supplies;
4. Ambulatory Surgery Center (see below provision);
5. Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures;
6. Oral *Surgery* related to trauma and *injury*, including services or appliances necessary for or resulting from medical treatment if the service is either emergency in nature or requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease; and
7. *Physician* contraceptive services and supplies including, but not limited to, vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.

Ambulatory Surgical Center

Outpatient Services and supplies provided at an in-*network* Ambulatory Surgery Center including:

1. Anesthesiology;
2. Surgical Services;
3. Laboratory Services;
4. Recovery Care;
5. Patient Care Services;
6. Surgical supplies; and
7. Facility costs (including services of staff Providers billed by the *Hospital*).

Attention Deficit/Hyperactivity Disorder

The diagnosis and treatment for Attention Deficit/Hyperactivity Disorder is *covered* when rendered or prescribed by a *physician*. *You* must pay the *copayment*, *deductible*, and *coinsurance* that apply to the type of provider rendering services for this condition.

Autism Spectrum Disorder Benefits

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

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

- evaluation and assessment services;
- *applied behavior analysis therapy*;
- behavior training and behavior management;
- *habilitation services* for individuals with a diagnosis of *autism spectrum disorder*;
- 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*.

Members who have not yet reached their twenty-first (21st) birthday are eligible for *applied behavior analysis* services. *Applied behavior analysis* is not covered for *members* age twenty-one (21) and older. 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*.

Chiropractic Services

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

Cleft Lip and Cleft Palate Services

The following services for treatment and correction of *cleft lip and cleft palate* are *covered*:

- oral and facial *surgery*, surgical management, and follow-up care;
- prosthetic treatment, such as obturators, speech appliances, and feeding appliances;
- orthodontic treatment and management;
- preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy;
- speech/language evaluation and therapy;
- audiological assessments and amplification devices;
- otolaryngology treatment and management;
- psychological assessment and counseling; and
- genetic assessment and counseling for patient and parents.

Coverage is also provided for secondary conditions and treatment attributable to the primary medical condition.

Contraception

All FDA-approved contraception methods (identified on www.fda.gov) are approved for *members* without *cost sharing* as required under the Affordable Care Act. *Members* have access to the methods available and outlined on *our* Drug Formulary or Preferred Drug List without *cost share*. Some contraception methods are available through a *member's* medical benefit, including the insertion and removal of the contraceptive device at no *cost share* to the *member*. This benefit contains both pharmaceutical and medical methods, including:

1. Sterilization *surgery* for women;
2. Surgical sterilization via implant for women;
3. Implantable rods;
4. Copper intrauterine devices;
5. Intrauterine devices with progestin;
6. The shot or injection;
7. Oral contraceptives (combined pill);
8. Oral contraceptives (progestin only);
9. Oral contraceptives (extended or continuous use);
10. The contraceptive patch;
11. Vaginal contraceptive rings;
12. Diaphragms;
13. Contraceptive sponges;
14. Cervical caps;
15. Female condoms;
16. Spermicides;
17. Emergency contraception; and
18. Additional methods as identified by the FDA.

COVID-19 Services

Approved diagnostic tests, antibody tests, and antiviral drugs that are ordered by *your physician* for the purpose of making clinical decisions or treating *you* if *you* are suspected of having COVID-19 are covered under this *contract*.

The approved diagnostic tests and antibody tests do not include a test used for employment-related or public health surveillance testing and, regardless of medical necessity, any COVID-19 diagnostic tests or antibody tests for those purposes are excluded from coverage.

Diabetic Care

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

Benefits are available for *medically necessary* items of diabetic supplies and blood glucose monitors (including non-invasive monitors and monitors for the blind) for which a *medical practitioner* has written an order.

Members that have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes or non-insulin diabetes may need to be educated on their condition and trained to manage their condition. *Coverage* is available for self-management training and education, dietician visits and for the equipment and necessary supplies for the training, if prescribed by the *member's physician*.

Dialysis Services

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

Covered expenses include:

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

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

Dietician Visits

Benefits are available for outpatient visits to registered dieticians. One (1) dietician visit is covered at no cost to *members* when performed by a *network provider*. All other subsequent dietician visits are covered according to the cost share as outlined in *your Schedule of Benefits*. Diabetics that need the services of a dietician should receive those services as part of their benefits for diabetic care.

Disposable Medical Equipment and Supplies

Disposable medical equipment and supplies, which have a primary medical purpose are covered and are subject to reasonable quantity limits as determined by *us*. The equipment and supplies are subject to the *member*'s medical *deductible* and *coinsurance*.

Durable Medical Equipment, Prosthetics, and Orthotic Devices

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

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

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

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

Benefits for repairs and replacement do not include the following:

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

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

Durable Medical Equipment

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

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

1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for IV fluids and medicine.
5. Glucometer.
6. Tracheotomy tube.
7. Cardiac, neonatal, and sleep apnea monitors.
8. 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.

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

Medical and surgical supplies

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

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

1. Allergy serum extracts.
2. Chem strips, Glucometer, Lancets.
3. Clinitest.

4. Needles/syringes.
5. Ostomy bags and supplies, except charges such as those made by a Pharmacy for purposes of a fitting, are not *covered services*.

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

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

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

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

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

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

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

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

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

Rehabilitation, and Extended Care Facility Expense Benefits

Covered service expenses include services provided or expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:

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

4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners.*
5. Outpatient physical therapy, occupational therapy, and physical therapy.

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

Care ceases to be *rehabilitation* upon *our* determination of any of the following:
1. The *member* has reached *maximum therapeutic benefit*.
2. Further treatment cannot restore bodily function beyond the level the *member* already possesses.
3. There is no measurable progress toward documented goals.
4. Care is primarily *custodial care*.

Habilitation Expense Benefits

Inpatient and outpatient *habilitation services* are a covered benefit. *Covered service expenses* include: physical, occupational and speech therapies, developmental services, *durable medical equipment* for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder.

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

Hearing Benefits

1. Benefits are available for hearing aids for *members* age 17 and under when obtained from a *network provider*. This benefit is limited to 1 hearing aid for each ear with hearing *loss* every 36 months. The hearing aid must be fitted and dispensed by a licensed audiologist, licensed hearing aid specialist or a hearing aid dealer after the medical clearance of a *physician* and an audiological evaluation medically appropriate to the age of the child. Note: A parent or guardian may choose a hearing aid for the child that is priced higher than the benefit payable (based on the *network* provider's contracted amount) and pay the difference between the price of the hearing aid and the benefit payable, without financial or contractual penalty to the provider of the hearing aid.
2. Implantable bone conduction hearing aids, cochlear implants and bone-anchored hearing aids (BAHA) are covered for all *members*, regardless of age, the same as any other service or supply, subject to *medical necessity* and payment of applicable *copayments*, *deductibles*, and *coinsurance*.

Home Health Care Service Expense Benefits

Covered services and supplies for *home health care* are covered when *your physician* indicates *you* are not able to travel for appointments to a medical office. Coverage is provided for *medically necessary* in-*network* care provided at the *member's* home and includes the following:
1. *Home health aide services*.
2. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to *your Schedule of Benefits* for any limits associated with this *benefit*.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
4. I.V. medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental of *medically necessary durable medical equipment*.
8. Sleep studies.

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

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

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

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

Hospice Care Service Expense Benefits

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

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

Benefits for *hospice inpatient*, home and outpatient care are available for 5 days per episode.

Exclusions and Limitations:
Any exclusion or limitation contained in the *policy* regarding:

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

Hospital Benefits

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

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

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

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

Medical and Surgical Expense Benefits

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

1. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies.
2. Made by a *physician* for professional services, including *surgery.*
3. Made by an assistant surgeon.
4. For the professional services of a *medical practitioner*, including *surgery*.
5. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
6. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).
7. For chemotherapy and radiation therapy or treatment.
8. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
9. For the cost and administration of an anesthetic.
10. For oxygen and its administration.
11. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the *Schedule of Benefits* for benefit levels or additional limits.
12. For accidental *dental services* when a *covered person* suffers an *injury,* after the *covered person's effective date* of coverage, that results in:
    a. Damage to the *member's* natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
13. For reconstructive breast *surgery* charges as a result of a partial or total mastectomy. Coverage includes *surgery* and reconstruction of the other breast to produce a symmetrical appearance, including but limited to contralateral prophylactic mastectomy, liposuction performed for transfer to a reconstructed breast or to repair a donor site deformity, tattooing the areola of the breast, surgical adjustments of the non-mastectomized breast, unforeseen medical complications which may require additional reconstruction in the future; prostheses; and treatment of physical complications of all stages of the mastectomy, including lymphedemas. These *covered services* shall be delivered in a manner determined in consultation with the attending *physician* and the *member*.
14. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the *Schedule of Benefits* for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *policy,* including the *deductible amount* and *percentage* provisions.
15. For the following types of tissue transplants:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.
    e. Implantable prosthetic lenses, in connection with cataracts.
16. 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.

17. *Medically necessary services* made by a *provider* who renders services in an in-*network urgent care center*, including facility costs and supplies.
18. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
19. Allergy testing.
20. *Medically necessary telemedicine services* subject to the same clinical and *utilization review* criteria, plan requirements, limitations and *cost sharing* as the same health care services when delivered to an insured in person.
21. For *medically necessary* genetic or molecular cancer testing, including but not limited to, tumor mutation testing, next generation sequencing, hereditary germline mutation testing, pharmacogenomics testing, whole exome, genome sequencing and biomarker testing.
22. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
23. For *medically necessary* biofeedback services.
24. For *medically necessary* allergy treatment.
25. Therapeutic abortion performed to save the life or health of the *member*, or as a result of incest or rape.
26. Cochlear implants and bone anchored hearing aids.
27. Second surgical opinions are *covered* subject to any *copayments, deductible* and *coinsurance*, but are not mandatory to receive benefits.

Interpreter Expenses for the Deaf or Hard of Hearing

Services performed by a qualified interpreter or transliterator are covered when you need such services in connection with medical treatment or diagnostic consultations performed by a *provider*, if the services are required because of hearing *loss* or your failure to understand or otherwise communicate in spoken language. Services rendered by a family member are not covered.

Low-Protein Food Products for Treating Inherited Metabolic Diseases

Low-protein food products for treating certain inherited metabolic disease are covered. Inherited metabolic diseases are diseases caused by an inherited abnormality of body chemistry. Low-protein food products are foods that are especially formulated to have less than 1 gram of protein per serving and are intended to be used under the direction of a *physician* for the dietary treatment of an inherited metabolic disease. Low protein food products do not include natural foods that are naturally low in protein.

Benefits for low-protein food products are limited to treating the following diseases:

- Phenylketonuria (PKU)
- Maple Syrup Urine Disease (MSUD)
- Methylmalonic Acidemia (MMA)
- Isovaleric Acidemia (IVA)
- Propionic Acidemia
- Glutaric Acidemia
- Urea Cycle Defects
- Tyrosinemia

Lymphedema Benefit

Treatment of lymphedema is covered when rendered or prescribed by a licensed *physician* or received in a *hospital* or other public or private facility authorized to provide lymphedema treatment. Coverage includes multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

Mental Health and Substance Use Disorder Benefits

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

Our behavioral health and substance use vendor oversees the delivery and oversight of covered *behavioral health* and *substance use disorder* services for Ambetter. If *you* need mental health or *substance use disorder* treatment, *you* may choose any *provider* participating in *our behavioral health* and substance use vendor's *provider network* and do not need a referral from *your PCP* in order to initiate treatment. *You* can search for in-*network Behavioral Health providers* by using *our* Find a Provider tool at https://www.louisianahealthconnect.com/ or by calling Member Services at 1-866-595-8133 (TTY/TDD 711). *Deductible amounts, copayment*, or *coinsurance* amounts and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

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

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

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

Inpatient

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

Outpatient

1. Individual and group mental health evaluation and treatment;
2. *Outpatient services* for the purpose of monitoring drug therapy;
3. Medication management services;
4. Outpatient detoxification programs;
5. Psychological and Neuropsychological testing and assessment;
6. Outpatient *rehabilitation* treatment;
7. *Applied behavioral analysis*;
8. Telemedicine;
9. Partial Hospitalization Program (PHP);
10. Intensive Outpatient Program (IOP);
11. Mental health day treatment;
12. Electroconvulsive Therapy (ECT);
13. *Transcranial magnetic stimulation (TMS)*;
14. *Assertive community treatment (ACT);*
15. The diagnosis and treatment for attention deficit/hyperactivity disorder when rendered or prescribed by a licensed *physician* or other *health care provider* licensed in this state and received in an appropriate setting.

In addition, Integrated Care Management is available for all of *your* health care needs including *behavioral health* and substance use. Please call 1-866-595-8133 (TTY/TDD 711) to be referred to a care manager for an assessment.

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

Other Dental Services

Anesthesia and *hospital* charges for dental care, for a *member* less than 19 years of age or a *member* who is physically or mentally disabled, are covered if the *member* requires dental treatment to be given in a *hospital* setting and for associated *hospital* charges when the *member's* mental or physical condition requires dental treatment to be rendered in a *hospital* setting . This coverage does not apply to treatment for temporomandibular joint disorders (TMJ).

Outpatient Medical Supplies Expense Benefits

Covered services and supplies for outpatient medical supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including *medically necessary* repairs or replacement to restore or maintain a *member's* ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per year per *covered person*.
3. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
4. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
5. For the rental of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint *surgery*.
6. For the cost of one wig per *covered person* necessitated by hair *loss* due to cancer treatments or traumatic burns.
7. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract *surgery*.

Pediatric Vision Expense Benefits – Children under the age of 19

Coverage for vision services is provided for children, under the age of 19, from a *network provider* through the end of the plan year in which they turn 19 years of age. This plan is compliant with the FEDVIP 2014 Vision Benefit Plan.

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;
    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*. Subject to prior *authorization*, *members* with low vision will receive the following:
    a. One comprehensive evaluation every 5 years. This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast and lighting requirements for optimum vision.
    b. 1 device per year such as high-power spectacles, magnifiers and telescopes. These devices maximum use of available vision, reduce problems of glare or increase contrast perception, based on the person's visual goals and lifestyle needs.
    c. 4 follow-up visits in any 5-year period.

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 https://www.louisianahealthconnect.com/ or call Member Services.

Covered service expenses do not include:

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

Vision Expense Benefits Routine Vision Adult aged 19 years of age and over

Coverage for vision services is provided for adults, age 19 and older, from a *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 https://www.louisianahealthconnect.com/ or call Member Services.

Services not covered:

1. Visual therapy; and
2. Low vision services and hardware for adults.

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; and
   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; and
   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 https://www.louisianahealthconnect.com/ or call Member Services.

Services not covered include:

1. *Dental services* that are not necessary or specifically covered;
2. Hospitalization or other facility charges;
3. *Prescription drugs* dispensed in the dental office;
4. Any dental procedure performed solely as a cosmetic procedure;
5. Charges for dental procedures completed prior to the *member*'s *effective date* of coverage;
6. Services provided by an anesthesiologist;
7. 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;
8. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles;
9. Any artificial material implanted or grafted into soft tissue or bone, surgical removal of implants, and implant services;
10. Sinus augmentation;
11. Surgical appliance removal;
12. Intraoral placement of a fixation device;
13. Oral hygiene instruction, tobacco counseling, nutritional counseling or high-risk substance abuse counseling;
14. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture;
15. Any oral *surgery* that includes surgical endodontics (apicoectomy and retrograde filling);
16. Analgesia (nitrous oxide);
17. Removable unilateral dentures;
18. Temporary procedures;
19. Splinting;
20. Temporal Mandibular Joint disorder (TMJ) appliances, therapy, films and arthorograms;
21. Oral pathology laboratory charges;

22. Consultations by the treating *provider* and office visits;
23. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
24. Veneers (bonding of coverings to the teeth);
25. Orthodontic treatment procedures;
26. Orthognathic *surgery*;
27. Athletic mouth guards;
28. Space maintainers;
29. Dental procedures or restoration to alter or increase vertical dimension of occlusion; and
30. Dental procedures or restorations to restore or repair *loss* of tooth structure caused by abrasion, abfraction, or erosion.

Prescription Drug Expense Benefits

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

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

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

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

Formulary or Prescription Drug List

This plan uses one *formulary* for all products covered under this *policy*. No product offered under this *policy* is issued without a *formulary*.

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. The *formulary* lists drugs on different tiers which represent varying cost share amounts. In general, drugs listed on lower *formulary* tier will be associated with lower *member* cost share amount. Most generic medications are listed on the lowest formulary cost share tier. 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 higher on the Drug List tier than generic drugs 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 that not all dosage forms or strengths of a drug may be covered. If a drug is not listed on the formulary it means that the drug is not covered and it is considered non-formulary. You have the right to request a non-formulary exception request review from us. Please review the Prescription Drug Exception Process section below for additional information.

This list is reviewed and updated at least quarterly. Positive changes, such as removal of utilization management restrictions and addition of drugs to the formulary can take place monthly. Negative changes, such as addition of Prior *Authorization* requirement will take place only at the beginning of each new

benefit year. The formulary is reviewed by our Pharmacy and Therapeutics Committtee (P&T). The P&T, consisting of practicing *physicians*, pharmacists and dentist, evaluates clinical aspects of each drug. Strategy Development Committee, a subcommittee of the P&T consisting of data analysts and pharmacists, determines the financial aspects of each drug. Together those two committees determine drug placement and any utilization management restrictions. If two drugs are clinically expected to produce same outcomes then the placement of the drug is based on financial aspects.

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the formulary. For the most current Ambetter Formulary or Prescription Drug List or for more information about *our* pharmacy program, visit https://www.louisianahealthconnect.com/ (under "For Member", "Pharmacy Resources") or call Member Services at 1-866-595-8133 (TTY/TDD 711).

Step Therapy
Step therapy means a utilization management policy for coverage of drugs that begins medication for a medical condition with the most preferred or cost effective drug therapy and progresses to other drug therapies if *medically necessary*. Step therapy is part of our formulary design and design of this plan.

Notice of Disclosure of Prescription Drug Formulary:
We offer several convenient ways to obtain and review current formulary and inquire if a drug is covered on the *formulary*. For the most current Ambetter Formulary or Prescription Drug List or for more information about *our* pharmacy program, visit https://www.louisianahealthconnect.com/ (under "For Member", "Pharmacy Resources") or call Member Services at 1-866-595-8133 (TTY/TDD 711). If a Prescription Drug is on your Prescription Drug Formulary, this does not guarantee that your prescribing healthcare provider will prescribe it for a particular medical condition or mental *illness*. We will disclose to you upon request, not later than the third business day after the date of the request, whether a specific drug is included in our drug formulary.

Notice on excess cost:
We use any savings or rebates to stabilize rates. Any savings or rebates we receive on the cost of drugs purchased under this *policy* from drug manufacturers are used to stabilize rates. You may be subject to an excess consumer cost burden when *covered prescription drugs* are purchased under this *policy*.

Notification to providers:
If a prescribed drug is denied based upon the drug's nonformulary status, we will provide the prescriber with a list of alternative comparable formulary medications in writing and attached to the letter of denial or electronically for requests made by providers utilizing electronic health records with capabilities. If a prescribed drug is excluded from coverage under the health benefit plan and other drugs in the same class and used for the same treatment as the excluded drug are covered under the plan, we will notify the prescriber of the covered drug in writing and attached to the letter of denial or electronically for requests made by providers utilizing electronic health records with capabilities.

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 https://www.louisianahealthconnect.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 https://www.louisianahealthconnect.com/. *You* can also request to have a copy mailed directly to *you*.

Mail Order Pharmacy
If *you* have more than one prescription *you* take regularly, *you* may select to enroll in *our* mail order delivery program. *Your* prescriptions will be safely delivered right to *your* door at no extra charge to *you*. *You* will still be responsible for *your* regular *copayment/coinsurance*. To enroll for mail order delivery or for any additional questions, call *our* mail order pharmacy at 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.

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

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 medications(s) only at specified location. *Ambetter* pharmacy, together with Medical Management will review *member* profiles and using specific criteria, will recommend *members* for participation in the Lock-In Program. *Members* identified for participation in the Lock-In Program and associated *providers* will be notified of *member* participation in the program via mail. Such communication will include information on duration of participation, pharmacy to which *member* is locked-in, and any *appeals* rights.

Medication Balance-On-Hand
Medication refills are prohibited until *your* 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
You are limited to 15-day supplies for the first 90 days when starting new therapy using certain medications (like oral oncology). *You* 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, you will fill your medications for 30-day supplies.

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

Exception to step therapy or fail first protocol:
We will grant exception to step therapy or fail first protocol when:

(1) The prescribing *physician* can demonstrate to the health coverage plan, based on sound clinical evidence, that the preferred treatment required under step therapy or fail first protocol has been ineffective in the treatment of the insured's disease or medical condition.

(2) The prescribing *physician* can demonstrate to the health coverage plan, based on sound clinical evidence, that the preferred treatment required under the step therapy or fail first protocol is reasonably expected to be ineffective based on the known relevant physical or mental characteristics and medical history of the insured and known characteristics of the drug regimen.

(3) The prescribing *physician* can demonstrate to the health coverage plan, based on sound clinical evidence, that the preferred treatment required under the step therapy or fail first protocol will cause or will likely cause an adverse reaction or other physical harm to the insured.

For product approved under this section we will issue an *approval* letter outlining coverage under this *policy*. For any product denied under this section *you* have the right to appeal *our* decision. Any product requested under this section will be reviewed within 72 hours of receipt of the request for standard requests and within 24 hours of receipt of urgent or exigent request.

Prescription Drug Exception Process

Standard exception request

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

Expedited exception request

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

If *we* do not respond to exception requests as outlined above, such exception should be deemed approved.

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. The independent review organization will make a determination on the external exception request and notify the *member*, the *member's* designee or the *member's* prescribing *physician* of the coverage determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception.

We will cover any medication approved under the exception requests described above for the duration stated on the original request or 12 months, whichever is shorter. Subsequent coverage may necessitate further reviews.

We do not apply fail first or step therapy protocols for drugs used in treatment of stage-four advanced metastatic cancer or associated conditions. This is reflected in our *prior authorization* criteria.

Notification of change in prescription drug or intravenous infusion coverage
If we change our coverage of a particular prescription drug or intravenous infusion based on medical necessity and you were utilizing this product in the past for at least 60 days, we will provide you with at least 60 days advanced notice of proposed change. You have the right to *appeal* this proposed change. To start the *appeal* process please reach out to your provider. Your provider can utilize regular appeals process for purposes of this section.

Change in formulary coverage
We will remove drugs from the formulary or otherwise restrict drugs with utilization management techniques only once a year at the time of the renewal.

Oral cancer drugs
We will provide oral cancer drugs at no less favorable terms than intravenously administer or injected cancer medications. This provision does not apply if you are on a High Deductible Health Plan or policies used together with a health savings account, medical savings account or similar program.

Cost share contribution
Any *copay* or *cost share* amount paid by you or on your behalf by a *third party* will be counted in *your* annual accumulators.

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

1. For *prescription drug* treatment of erectile dysfunction or any enhancement of sexual performance 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. This exclusion does not apply to prescribed FDA approved contraceptive methods.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for *investigational* or *experimental* drugs.
10. For any drug that *we* identify as therapeutic duplication through the Drug Utilization Review program.
11. For more than a 30-day supply when dispensed in any one prescription or refill, or for some maintenance drugs, up to 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply *network*. Specialty drugs and other select drug categories are limited to 30-day supply when dispensed by retail or mail order. Please note that only the 90-day supply is subject to the discounted *cost sharin*g. Mail orders less than 90 days are subject to the standard *cost sharing* amount.
12. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
13. Foreign Prescription Medications, except those associated with an *emergency medical condition* while *you* are traveling outside the United States. These exceptions apply only to medications with

an equivalent FDA-approved Prescription Medication that would be covered under this document if obtained in the United States.

14. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventive treatment is related to *member's* vacation during out of country travel. This 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 drug dispensed from a non-lock-in pharmacy while *member* is in a lock-in program.
21. For any drug related to *surrogate pregnancy*.
22. For any drug used to treat hyperhidrosis.
23. For any injectable medication or biological product that is not expected to be self-administered by the *member* at *member's* place of *residence* unless listed on the formulary.
24. Medication refills where a *member* has more than 15 days' supply of medication on hand.

Preventive Care Expense Benefits

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

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. Examples of these services are screenings for breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, prostate specific antigen testing, and screenings for child and adult obesity.
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 including screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum.
5. Covers without *cost sharing*:
    a. Routine wellness physical exam – certain routine wellness diagnostic tests ordered by *your physician* are covered. Examples of routine wellness diagnostic tests include tests such as a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol and blood sugar levels.
    b. Well baby care – routine examinations will be covered for infants younger than 24 months old for whom no diagnosis is made.
    c. Routine annual visits to an obstetrician or gynecologist. Additional visits that *your* obstetrician or gynecologist recommends may be subject to a *deductible amount*, *copayment* or *coinsurance* percentage shown on the *schedule of benefits*, unless they are preventive services.
    d. One routine pap smear per *benefit period*.

e. All film mammograms, 3-D mammograms (digital breast tomosynthesis), and breast ultrasounds are covered at no cost to you when obtained from a *network provider*. Note: mammograms considered diagnostic may be subject to *cost sharing*.
f. Bone Mass Measurement – scientifically proven tests for diagnosing and treating osteoporosis if a Member is:
    i. An estrogen deficient woman at clinical risk of osteoporosis who is considering treatment;
    ii. An individual receiving long-term steroid therapy; or
    iii. An individual being monitored to assess the response to or efficiency of approved osteoporosis drug therapies.
g. BRCA1 & BRCA2 Genetic Testing – genetic testing of BRCA1 and BRCA2 genes will be covered at no cost to *you* to detect an increased risk of breast and ovarian cancer when recommended by a healthcare provider in accordance with the United States Preventive Services Task Force.
h. Screening for nicotine or tobacco use; and
i. 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 health care *provider* without *prior authorization*.

Benefits for preventive health services listed in this provision, are exempt from any *deductible amounts, cost sharing percentage* provisions, and *copayment amounts* under the *policy* when the services are provided by a *network provider.* If a service is considered diagnostic or non-preventive, *your* plan *copayment*, *coinsurance*, and *deductible* will apply. It's important to know what type of service *you 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.

Clinical Trial Coverage

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

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

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

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

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

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

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

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

Colorectal Cancer Examinations and Laboratory Tests

Covered service expenses include "colorectal cancer tests" for any non-symptomatic *covered person*, in accordance with the recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.

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*.

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.

Mammography

We include benefits payable for minimum mammography examination, including but not limited to digital breast tomosynthesis (DBT). Minimum mammography examination means mammography examinations performed no less frequently than the following schedule provides:

- One baseline mammogram for any woman who is 35 through 39 years of age.
- Annual mammogram (DBT preferred modality) for any woman who is 40 or older.
- Consideration is given to women with a hereditary susceptibility from pathogenic mutation carrier status or prior chest wall radiation, an annual MRI starting at age 25 and annual mammography (DBT preferred modality) starting at age 30.

Such examinations shall be in accordance with recommendations by National Comprehensive Cancer Network guidelines or the American Society of Breast Surgeons Position Statement on Screening Mammography no later than the following policy or plan year following changes in the recommendations. Annual mammography (DBT preferred modality) and access to supplemental imaging (MRI preferred modality) starting at age thirty-five upon recommendation by her *physician* if the woman has a predicted

lifetime risk greater than twenty percent by any validated model published in peer reviewed medical literature.

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 artificial insemination (AI) in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT).

Maternity Care

Coverage for outpatient and *inpatient* pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and *hospital* stays for delivery or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or *cost sharing percentage*). An *inpatient* stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. *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 to *us*. Other maternity benefits include *complications of pregnancy,* parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests. Coverage will only be provided for maternity services or care of the newborn child when such services have been *authorized* by *your* participating health care *provider*.

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 health care *provider* obtain *authorization* for prescribing a length of stay of up to 48 hours (or 96 hours).

Note: This provision does not amend the *policy* to restrict any terms, limits, or conditions that may otherwise apply to *covered service expenses* for maternity care.

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

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

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

Duty to Cooperate
We do not cover services or supplies related to a *member*'s *pregnancy* when a *member* is acting as a *surrogate* and has entered into a *surrogacy arrangement*. For more information on excluded services, please see the General Non *Covered Services* and Exclusions section. *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 Ambetter of Louisiana Healthcare Connections, Member Services, 8585 Archives Avenue, Suite 310, Baton Rouge, LA 70809. In the event that a *member* fails to comply with this provision, *we* reserve *our* right to enforce this *policy* on the bases of fraud, misrepresentation or false information, up to and including recoupment of all benefits that *we* paid on behalf of the *surrogate* during the time that the *surrogate* was insured under *our policy*, plus interest, attorneys' fees, costs and all other remedies available to *us*.

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.

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

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

Metastatic or Unresectable Tumors
We cover metastatic or unresectable tumors with a *medically necessary* drug prescribed by a *physician* on the sole basis that the drug is not indicated for the location in the body of the patient's cancer if the drug is approved by the United States Food and Drug Administration for the treatment of the specific mutation of the patient's cancer. *Coverage* is included for an initial treatment period of three (3) months. *Coverage* shall continue after the initial treatment period, if the treating *physician* certifies that the drug is *medically necessary* based on documented improvement of the patient.

Prostate Specific Antigen Testing
Covered service expenses include one (1) digital rectal exam and prostate-specific antigen (PSA) test per benefit period, is covered for *members* 50 years of age or older, and as recommended by his *physician* if the *member* is over 40 years of age. *Your* individual *deductible* does not apply.

A second visit will be permitted if recommended by *your physician* for follow-up treatment within 60 days and after either visit if related to a condition diagnosed or treated during the visits.

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).

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 *copayment* for the consultation. Any lab tests and/or diagnostic and therapeutic services are subject to the additional *copayment*.

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

Social determinants of health benefits and services may be offered to *enrollees* through the "My Health Pays" wellness program and through local health plan websites. *Enrollees* may receive notifications about available benefits and services through emails from local health plans and through the "My Health Pays" notification system. To inquire about these benefits and services or other benefits available, *you* may visit *our* website at https://www.louisianahealthconnect.com/ or by contacting Member Services at 1-866-595-8133 (TTY/TDD 711).

Transplant Expense Benefits

Covered Services For Transplant Service Expenses:

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

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

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

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

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

1. *We* will pay for the following services when the *enrollee* is required to travel more than 75 miles from the *residence* to the *Center of Excellence*:
2. *We* will pay a maximum of $10,000 per transplant service for the following services:
    a. Transportation for the *enrollee*, any live donor, and the *immediate family* to accompany to and from the *Center of Excellence*, in the United States.
    b. When *enrollee* and/or donor is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
    c. Maximum reimbursement for mileage is limited to travel to and from the *member's* home to the transplant facility, and to and from the donor's home to the transplant facility, and will be reimbursed at the current IRS mileage standard for miles driven for medical purposes.
    d. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *enrollee* while the *enrollee* is confined in the *Center of Excellence* in the United States. *We* will reimburse *members* for the proof of costs directly related for

transportation, lodging and any of the following approved items listed in the *member* transplant reimbursement guidelines. However, *you* must make the arrangements and provide the necessary paid receipts for reimbursement within 6 months of the date of service in order to be reimbursed.

e. Incurred costs related to a certified/registered service animal for the transplant *enrollee* and/or donor.
f. Please refer to the *member* resources page for *member* reimbursement transplant travel forms and information at www. Ambetter.com.

Non-*Covered Services* and Exclusions:
No benefits will be provided or paid under these Transplant Service 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 un*authorized* facility or not obtained through the *Center of Excellence*.
9. For any transplant services and/or travel related expenses for *enrollee* and donor, when preformed outside of the United States.
10. The following ancillary items listed below, will not be subject to *member* reimbursement under this *policy*:
    a. Alcohol/tobacco
    b. Car Rental (unless pre-approved by Case Management)
    c. Vehicle Maintenance for motorized and hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.)
    d. Parking, such as but not limited to hotel, valet or any offsite parking other than *hospital*.
    e. Storage rental units, temporary housing incurring rent/mortgage payments.
    f. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
    g. Speeding tickets
    h. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
    i. For any services related to pet care, boarding, lodging, food, and/or travel expenses; other than those related to certified/registered service animal(s).
    j. Expenses for persons other than the patient and his/her covered companion
    k. Expenses for lodging when *member* is staying with a relative
    l. Any expense not supported by a receipt
    m. Upgrades to first class travel (air, bus, and train)
    n. Personal care items (e.g., shampoo, deodorant, clothes)
    o. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA pre-check, and early check-in boarding fees, extra baggage fees.
    p. Souvenirs (e.g., t-shirts, sweatshirts, toys)
    q. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type.
    r. All other items not described in the *policy* as eligible expenses
    s. Any fuel costs / charging station fees for electric cars.

Organ Transplant Medication Notification
Members will not be subject to 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 during the enrollment year, *We* must, to the extent possible, notify the prescribing *physician* and the patient, or the parent or legal guardian if the *member* is a child, or the *spouse*/caretaker of a *member* who is *authorized* to consent to the treatment of the *member* 60 days prior to renewal or enrollment. 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 *member* 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 *member* requests a refill of the immunosuppressant drug, *we* may provide the *member* with the written notification required above along with a 60-day supply of the immunosuppressant drug under the same terms as previously allowed.

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

Members are encouraged to contact their *primary care provider* for an appointment before seeking care from another *provider*, but *network urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *primary care provider* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-866-595-8133 (TTY/TDD 711). The 24/7 Nurse Advice Line is available twenty-four (24) hours a day, seven (7) days a week. A registered nurse can help *you* decide the kind of care most appropriate for *your* specific need.

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

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

You may obtain information regarding the particular programs available at any given time by visiting *our* website at https://www.louisianahealthconnect.com/ or by contacting Member Services by telephone at 1-866-595-8133 (TTY/TDD 711). The benefits are available as long as coverage remains active, unless changed by *us* as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All *members* are automatically eligible for program benefits upon obtaining coverage. These 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 1-866-595-8133 (TTY/TDD 711).

General Non-Covered Services and Exclusions

No benefits will be provided or paid for:

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

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*, except as expressly provided for under the Benefits after Coverage Terminates clause in this *policy's* Termination section.
2. For any portion of the charges that are in excess of the *eligible service expense.*
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*, bariatric *surgery* and weight *loss* programs, except as specifically covered in the Major Medical Expense Benefits section of the *policy*.
4. For the reversal of sterilization and the reversal of vasectomies.
5. For non-therapeutic abortion.
6. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Major Medical Expense Benefits provision.
7. For expenses for television, telephone, or expenses for other persons.
8. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
9. For telephone consultations or for failure to keep a scheduled appointment.
10. For stand-by availability of a *medical practitioner* when no treatment is rendered.
11. For *dental service* expenses*,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits.
12. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* or is performed to correct a birth defect in a child.
13. Mental health services are excluded for:
    a. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
    b. Pre-marital counseling;
    c. Court ordered care or testing or required as a condition of parole or probation. Benefits will be allowed for services that are *medically necessary* and would otherwise be covered under this *policy*;
    d. Testing of aptitude, ability, intelligence or interest; and
    e. Evaluation for the purpose of maintain employment.

14. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
15. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.
16. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
17. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *policy)*.
18. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*.
19. 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.
20. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *policy*.
21. For hearing aids, except as expressly provided in this *policy*.
22. 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. Costs of *investigational treatment(s)* and costs of associated protocol-related patient care shall be covered only if the following criteria are met:
    a. The treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer.
    b. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer.
    c. The treatment is being provided in accordance with a clinical trial approved by qualifying entities.

    A health insurance issuer is not required to provide coverage for:
        1. Non-healthcare services.
        2. Costs for managing research data.
        3. Investigational drugs, devices, items or services.
23. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of ninety (90) consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
24. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's* workers' compensation claim, this exclusion will still apply unless that denial is *appealed* to the proper governmental agency and the denial is upheld by that agency.
25. For or related to treatment of hyperhidrosis (excessive sweating).
26. For fetal reduction *surgery*.
27. Except as specifically identified as a *covered service expense* under the *policy*, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
28. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or Semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); racing or speed testing

any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).

29. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
30. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
31. For the following miscellaneous items: Artificial Insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *rehabilitation* services for the enhancement of job, athletic, or recreational performance; routine or elective care outside the *service area*; treatment of spider veins; transportation expenses, unless specifically described in this *policy*.
32. Diagnostic testing, laboratory procedures screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
33. For court ordered testing or care unless *medically necessary*.
34. For a *member's illness* or *injury* which is caused by the acts or omissions of a *third party*, *we* have a right of recovery for any benefits paid in excess. *Our* right of subrogation is secondary to the right of the member to be fully compensated for his damages.
35. *Surrogacy arrangement*. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a *member*, and any child born as a result of a *surrogacy arrangement*. This exclusion applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the *surrogate* following childbirth);
    d. Mental Health Services related to the *surrogacy arrangement*;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
    h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement*;
    i. Any complications of the child or *surrogate* resulting from the *pregnancy*; or
    j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*.

    Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except where the child is the adoptive child of insureds possessing an active *policy* with *us* and/or the child possesses an active *policy* with *us* at the time of birth.
36. For any medicinal and recreational use of cannabis or marijuana.
37. Any non-*medically necessary* court ordered care for a medical/surgical or mental health/*substance use disorder* diagnosis, unless required by state law.
38. Expenses for services related to immunizations for travel and occupational purposes.
39. Expenses for services related to massage therapist.
40. Expenses for services related to naprapathic services; and
41. Expenses for services related to naturopathic services.
42. Expenses for services related to temporomandibular joint (TMJ).

Termination

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *policy*;
2. The date *we* receive a request from *you* to terminate this *policy,* or any later date stated in *your* request, or if *you* are enrolled through the Health Insurance Marketplace, the date of termination that the Health Insurance Marketplace provides *us* upon *your* request of cancellation to the Health Insurance Marketplace;
3. The date *we* decline to renew this *policy,* as stated in the Discontinuance provision;
4. The date of *your* death, if this *policy* is an Individual Plan; or
5. The date a *member's* eligibility for coverage under this *policy* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *policy*

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

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

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

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

Benefits After Coverage Terminates
Benefits for *covered service expenses* incurred after a *member* ceases to be covered are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *policy* is terminated because of:

1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss*. The *period of extended loss* must begin before coverage of the *member* ceases under this *policy*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *policy* is terminated because *we* refuse to renew all policies issued on this form, to residents of the state where *you* live, termination of this *policy* will not prejudice a claim for a *continuous loss* that begins before coverage of the *member* ceases under this *policy.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

Right of Reimbursement

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

Louisiana Healthcare Connections' rights of recovery apply to any recoveries made by or on behalf of the *member* from any sources, including but not limited to:

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

To the extent that benefits for *covered services* are provided or paid under this contract, we will be subrogated and will succeed to your right for the recovery of the amount paid under this contract against any person, organization or other carrier even where such carrier provides benefits directly to you. The acceptance of such benefits hereunder will constitute such subrogation. Our right to recover will be subordinate to your right to be "made whole." We will be responsible for our proportionate share of the reasonable attorney fees and costs actually incurred by you in pursuing recovery.

By accepting benefits under this plan, the *member* specifically acknowledges Louisiana Healthcare Connections' right of recovery. Louisiana Healthcare Connections may proceed against any party with or without the *member's* consent.

By accepting benefits under this plan, the *member* also specifically acknowledges *our* right of reimbursement. This right of reimbursement attaches when this plan has provided health care benefits for expenses incurred due to *third party* injuries and the *member* or the *member's* representative has recovered any amounts from any source. Our right to recover will be subordinate to your right to be "made whole." We will be responsible for our proportionate share of the reasonable attorney fees and costs actually paid by you in pursuing recovery. *Our* right of reimbursement is cumulative with and not exclusive of Louisiana Healthcare Connections' right of recovery and *we* may choose to exercise either or both rights of recovery.

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

1. To fully cooperate with *us* in order to obtain information about the *loss* and its cause.
2. To *immediately* inform *us* in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.
3. To include the amount of benefits paid by *us* on behalf of a *member* in any claim made against any *third party*.
4. To give Louisiana Healthcare Connections a first-priority lien on any recovery, settlement or judgment or other sources of compensation which may be had from any party to the extent of the full cost of all benefits associated with *third party* injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
5. To pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due Louisiana Healthcare Connections as reimbursement for the full cost of all benefits associated with *third party* injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement).

6. That *we*:
    a. Will have a lien on all money received by a *member* in connection with the *loss* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.
    d. Are entitled to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert the right of reimbursement independently of the *member*.
7. To take no action that prejudices *our* reimbursement rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan.
8. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement rights.
9. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
10. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
11. That *we* may reduce other benefits under the *policy* by the amounts a *member* has agreed to reimburse *us*.

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.

Coordination of Benefits

Applicability

1. This Coordination of Benefits ("COB") section applies to this Plan when a *member* has healthcare coverage under more than one Plan. "Plan" is defined below.
2. This section is intended to describe the Order of Benefit Determination Rules that govern the order in 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 in accordance with its policy 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% of the total Allowable Expense.

Definitions (Applicable only to this section of the *policy*)

1. "Allowable Expense" means any healthcare service or expense, including *deductibles*, *coinsurance* or *copayments*, that is covered in full or at least in part by any Plan covering the person.
    a. 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.
    b. An expense or a portion of an expense that is not covered by any of the Plans is not an Allowable Expense.
    c. The following are examples of expenses that are not Allowable Expenses.
        i. If a person is confined in a private *Hospital* room, the difference between the cost of a semi-private room in the *Hospital* and the private room is not an Allowable Expense, unless one of the Plans provides coverage for private *Hospital* room expenses.
        ii. If a person is covered by two or more Plans that compute their Benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the Provider in excess of the highest reimbursement amount for a specified Benefit is not an Allowable Expense.
        iii. If a person is covered by two or more Plans that provide Benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.
    d. The following are examples of expenses that are Allowable Expenses.
        i. If a person is covered by one Plan that calculates its Benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan that provides its Benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans.
        ii. The amount of any Benefit reduction by the Primary Plan because a *covered person* has 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.
2. "Closed Panel Plan" a Plan that provides health Benefits to *covered persons* primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that excludes Benefits for services provided by other Providers, except in cases of emergency or referral by a panel member.
3. "Coordination of Benefits or 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.

4. "Custodial Parent"
    a. the parent awarded custody of a child by a court decree; or
    b. in the absence of a court decree, the parent with whom the child resides more than one half of the *calendar year* without regard to any temporary visitation.
5. "Order of Benefit Determination Rules" determine whether this Plan is a Primary Plan or Secondary Plan when the person has 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.
6. "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.
    a. Plan includes:
        i. Group and non-group Insurance Contracts;
        ii. Health Maintenance Organization (HMO);
        iii. group and non-group coverage through Closed Panel Plans;
        iv. Group-Type Contracts (whether insured or uninsured);
        v. the medical care components of long-term care Contracts, such as skilled nursing care;
        vi. the medical Benefits under group or individual automobile Contracts;
        vii. Medicare or other governmental Benefits, as permitted by law.
    b. Plan does not include:
        i. *hospital* indemnity coverage Benefits or other fixed indemnity coverage;
        ii. accident only coverage;
        iii. specified disease or specified accident coverage;
        iv. limited Benefit health coverage as defined by state law;
        v. school accident-type coverage except those enumerated in LSA-R.S. 22:1000 A.3C;
        vi. Benefits provided in long-term care insurance policies for non-medical services;
        vii. Medicare supplement policies;
        viii. a state plan under Medicaid; or
        ix. coverage under other federal government plans, unless permitted by law.

    Each Contract for coverage under a or b, listed 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.

Order of Benefit Determination Rules

1. When a person is covered by two or more Plans, the rules for determining the order of Benefit payments are as follows:
    b. The Primary Plan pays or provides its Benefits according to its terms of coverage and without regard to the benefits of under any *other Plan*.
        i. Except as provided in Paragraph (2) below, a Plan that does not contain a Coordination of Benefits Provision that is consistent with this section is always primary unless the provisions of both Plans state that the complying Plan is primary.
        ii. 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 the supplementary coverage shall be excess to any other parts of the Plan provided by the Policyholder. 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*.

2. Each Plan determines its order of Benefits using the first of the following rules that apply:
   a. Non-Dependent or Dependent Rule. The Plan that covers the person other than as a Dependent, for example as an Employee, *Member*, policyholder, *Subscriber* or retiree is the Primary Plan and the Plan that covers the person as a Dependent is the Secondary Plan. However, if the person is a Medicare Beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (e.g. a retired Employee); then the order of Benefits between the two Plans is reversed so that the Plan covering the person as an Employee, *Member*, policyholder, *Subscriber* or retiree is the Secondary Plan and the *other Plan* is the Primary Plan.
   b. Dependent Child Covered Under More Than One Plan Rules. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of Benefits is determined as follows:
      i. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
         (a) The Plan of the parent whose Birthday falls earlier in the *calendar year* is the Primary Plan; or
         (b) If both parents have the same Birthday, the Plan that has covered the parent the longest is the Primary Plan.
      ii. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
         (1) If a court decree states that one of the parents is responsible for the Dependent 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;
         (2) If a court decree states that both parents are responsible for the Dependent child's healthcare expenses or healthcare coverage, the provisions of Subparagraph (1) above shall determine the order of Benefits;
         (3) 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 Dependent child, the provisions of Subparagraph (1) above shall determine the order of Benefits; or
         (4) If there is no court decree allocating responsibility for the Dependent child's healthcare expenses or healthcare coverage, the order of Benefits for the child are as follows:
            A. The Plan covering the Custodial Parent;
            B. The Plan covering the *Spouse* of the Custodial Parent;
            C. The Plan covering the non-Custodial Parent; and then
            D. The Plan covering the *Spouse* of the non-Custodial Parent.
      iii. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraphs (1) or (2) above shall determine the order of Benefits as if those individuals were the parents of the child.
      iv. For a Dependent child covered under the *Spouse's* Plan:
         (1) For a Dependent child who has coverage under either or both parents' Plans and also has his or her own coverage as a Dependent under a *Spouse's* Plan, the Longer or Shorter Length in Coverage Rule applies.
         (2) In the event the Dependent child's coverage under the *Spouse's* Plan began on the same date as the Dependent child's coverage under either or both parents' Plans,

the order of Benefits shall be determined by applying the birthday rule above in Subparagraph (1) to the Dependent child's parent(s) and the Dependent's *Spouse*.

d. Active Employee or Retired or Laid-off Employee Rule. The Plan that covers a person as an active Employee, that is, an Employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off Employee is the Secondary Plan. The same would hold true if a person is a Dependent of an active Employee and that same person is 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 of Subparagraph (2) can determine the order of Benefits.
e. COBRA or State Continuation Coverage Rule. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an Employee, *Member*, *Subscriber* or retiree or covering the person as a Dependent of an Employee, *Member*, *Subscriber* or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the *other Plan* does not have this rule, and as a result, the Plans do not agree on the order of Benefits, this rule is ignored. This rule does not apply if the rule of Subparagraph (2) determine the order of Benefits.
f. Longer or Shorter Length of Coverage Rule. The Plan that covered the person as an Employee, *Member*, policyholder, *Subscriber* or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
g. Fall-Back Rule. If none of the preceding rules determine the order of Benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In any event, this Plan will never pay more than it would have paid had it been the Primary Plan.

Effects on the Benefits of this Plan

1. When this Plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all Plans during a Plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any Claim, the Secondary Plan will 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 shall credit to its Plan *Deductible*, *Coinsurance*, *Copayments* and any amounts it would have credited to its *Deductible* in the absence of other healthcare coverage. In any event, This Plan will never pay more than it would have paid had it been the Primary Plan.
2. The difference between the Benefit payments that this Plan would have paid had it been the Primary Plan, and the Benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the *covered person* and used by this Plan to pay any Allowable Expenses, not otherwise paid during the Claim determination period. As each Claim is submitted, this Plan will:
    a. Determine its obligation to pay or provide benefits under its contract;
        i. Determine whether a benefit reserve has been recorded for the *covered person*; and
        ii. Determine whether there are any unpaid Allowable Expenses during that claim determination period.
3. If there is a benefit reserve, the Secondary Plan will use the *covered person's* benefit reserve to pay up to 100 percent of total Allowable Expenses incurred during the Claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new Claim determination period.
4. If a *covered person* is 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 Plans.

You may request a copy in either paper form or electronic form of Appendix C, which provides an

explanation for Secondary Plans on the purpose and use of the benefit reserve and how Secondary Plans calculate Claims. A copy of Appendix C is also available on the Louisiana Department of Insurance's website at https://www.ldi.la.gov/docs/default-source/documents/legaldocs/regulations/reg32appendixc.pdf?sfvrsn=24e14b52_0.

Summary

This is a summary of only a few of the provisions of your health Plan to help you understand Coordination of Benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language above, which determines your Benefits.

1. Double Coverage

It is common for family members to be covered by more than one healthcare plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers. When you are covered by more than one health plan, state law permits your insurers to follow a procedure called "Coordination of Benefits" to determine how much each should pay when you have a Claim. The goal is to make sure that the combined payments of all Plans do not add up to more than your covered healthcare expenses. Coordination of Benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones.

2.Primary or Secondary

You will be asked to identify all the Plans that cover members of your family. We need this information to determine whether we are the "primary" or "secondary" Benefit payer. The Primary Plan always pays first when you have a Claim. Any Plan that does not contain your state's COB rules will always be primary.

3. When this Plan is Primary

If you or a family member are covered under another Plan in addition to this one, we will be primary when:

a. The Claim is for your own healthcare expenses, unless you are covered by Medicare and both you and your *Spouse* are retired;
b. The Claim is for your *Spouse*, who is covered by Medicare, and you are not both retired;
c. The Claim is for the healthcare expenses of your child who is covered by this Plan and:
    i) You are married and your birthday is earlier in the year than your *Spouse's* or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the birthday rule;
    ii) You are separated or divorced and you have informed us of a court decree that makes you responsible for the child's healthcare expenses; or
    iii) There is no court decree, but you have custody of the child.

4.Other Situations

a. We will be primary when any other provisions of state or federal law require us to be. When we are the Primary Plan, we will pay the Benefits in accordance with the terms of your Contract, just as if you had no other healthcare coverage under any *other Plan*.
b. We will be secondary whenever the rules do not require us to be Primary. When we are the Secondary Plan, we do not pay until after the Primary Plan has paid its Benefits. We will then pay part or all of the Allowable Expenses left unpaid, as explained below. An "Allowable Expense" is a healthcare service or expense covered by one of the Plans, including *Copayments*, *Coinsurance* and *Deductibles.*
    i) If there is a difference between the amount the Plans allow, we will base our payment on the higher amount. However, if the Primary Plan has a Contract with the Provider, our combined payments will not be more than the Contract calls for. Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) usually have Contracts with their Providers.
    ii) We will determine our payment by subtracting the amount the Primary Plan paid from the amount we would have paid if we had been primary. We will use any savings to pay the

balance of any unpaid Allowable Expenses covered by either Plan.

iii) If the Primary Plan covers similar kinds of healthcare expenses, but allows expenses that we do not cover, we will pay for those items as long as there is a balance in your benefit reserve, as explained below.

iv) We will not pay an amount the Primary Plan did not cover because you did not follow its rules and procedures. For example, if your Plan has reduced its Benefit because you did not obtain pre-certification, as required by that plan, we will not pay the amount of the reduction, because it is not an Allowable Expense.

c. Benefit Reserve
When we are secondary we often will pay less than we would have paid if we had been primary. Each time we "save" by paying less, we will put that savings into a benefit reserve. Each family member covered by this Plan has a separate benefit reserve. We use the benefit reserve to pay Allowable Expenses that are covered only partially by both Plans. To obtain a reimbursement, you must show us what the Primary Plan has paid so we can calculate the savings. To make sure you receive the full Benefit or coordination, you should submit all Claims to each of your Plans. Savings can build up in your reserve for one year. At the end of the year any balance is erased, and a fresh benefit reserve begins for each person the next year as soon as there are savings on their Claims.

Right to receive and release needed information
Certain facts are needed to apply these COB rules. We have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Plan must give us any facts we need to pay the Claim.

Facility of Payment
A payment made under another Plan may include an amount that should have been paid under this Plan. 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. To the extent, such payments are made; they discharge Us from further liability. The term “payment made” includes providing Benefits in the form of services, in which case the payment made will be deemed to be the reasonable cash value of any Benefits provided in the form of services.

Right of Recovery
If the amount of the payments that We made is more than it should have paid under this COB section, We may recover the excess. We may get such recovery or payment from one or more of:

1. The persons we have paid or whom we have paid;
2. Insurance companies; or
3. Other organizations.

The “amount of the payments made” includes the reasonable cash value of any Benefits provided in the form of services.

Claims

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

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 15 months from date services rendered will not be accepted.

Indemnity claims payable under this *policy* for any *loss* other than loss of time on account of disability will be paid *immediately* upon receipt of written proof of such *loss*. Subject to written *proof of loss*, accrued indemnity claims for loss of time on account of disability will be paid (insert period of payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid *immediately*.

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

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

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

To request reimbursement for a *covered service*, *you* need a copy of the detailed claim from *your provider*. *You* also need to submit an explanation of why *you* paid for the *covered services* along with the *member* reimbursement claim form posted at https://www.louisianahealthconnect.com/ under "Member Resources". Send all the documentation to *us* at the following address:

Ambetter from Louisiana Healthcare Connections
Attn: Claims Department
8585 Archives Avenue, Suite 310
Baton Rouge, LA 70809

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

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

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

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

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

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

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

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

Claims submitted for services received by a deceased *member* will be payable in accordance with the *beneficiary* designation and the provisions respecting such payments. If no such designation or provision is provided, claims will be payable to the estate of the *member*. Any other claims unpaid at the *member*'s death may, at *our* option, be paid to the *beneficiary*. All other claims will be payable to the *member* or to the *provider*, at *our* option.

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

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

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

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

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

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

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

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

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

Physical Examination
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.

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 one year after the date *proof of loss* is required.

Grievance, Appeal, and External Review Procedures

Internal Procedures

Grievance
Ambetter of Louisiana Healthcare Connections has a *grievance* procedure which allows the *member* the opportunity to resolve the *member's* issues and *complaints*. The process is voluntary and is available for review of the policy, quality of care or quality of service issues that affect the *member*. The *grievance* process does not apply to *complaints* based solely on the basis that the policy does not cover the service or limits benefits for the health care service in question, provided that the exclusion of the specific service requested is clearly stated in the *policy.*

Grievances are normally, but not limited to, the following concerns:

1. Availability, delivery, or quality of health care services, including a *complaint* regarding an *adverse determination* made pursuant to *utilization review*.
2. Claims payment, handling, or reimbursement for health care services.
   Matters pertaining to the contractual relationship between a *covered person* and a health insurance issuer.

Filing a Grievance
Grievances may be requested by a *member* or the *member's authorized representative*. *Grievances* may be filed orally by calling 1-866-595-8133 (TTY/TDD 711) or in writing by mailing *us* a letter or the *Grievance* and *Appeal* Form from our website to:

Ambetter from Louisiana Health Care Connections
PO Box 10341
Van Nuys, CA 91410
1-833-886-7956

A *member* or the *member's authorized representative* has the right to submit written comments, documents, records, and other information relating to the claim for benefits, and the right to review the claim file and to present evidence and testimony as part of the internal review process.

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

An eligible grievant is:

1. A *member*;
2. Person authorized (orally or in writing) to act on behalf of the *member*. **Note:** Written *authorization* is not required; however, if received, *we* will accept any written expression of *authorization* without requiring specific form, language, or format;
3. In the event the *member* is unable to give consent: a *spouse*, family member, or the treating *provider*.

   Important: *Adverse determinations* that are not *grievances* will follow standard Patient Protection and Affordable Care Act (PPACA) internal *appeals* procedures.

Acknowledgement
Within 5 business days of receipt of a *grievance*, a written acknowledgment to the *member* or the *member's authorized representative* confirming receipt of the *grievance* must be delivered or deposited in the mail.

When acknowledging a *grievance* filed by an *authorized representative*, the acknowledgement shall include

a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.

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

Resolution Timeframes
We will issue a written decision, in clear terms, to the *member* and *authorized representative*, if applicable, within 30 calendar days after receiving the *grievance*.

Right to Participate
A *member* or the *member's authorized representative*, who has filed a *grievance* has the right to submit comments to the Grievances and Appeals Department. The *member* or *authorized representative* is entitled to request a copy of documentation reviewed by the Grievances and Appeals Department in making its determination.

Written Grievance Response
Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reasons for the denial, determination, or initiation of disenrollment.

Our written decision to the *member* must include:
1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *grievance;*
3. A written description of position titles of the persons involved in making the decision;
4. A clear explanation of the decision;
5. A statement that the *member* is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *member 's* claim for benefits; and
6. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse determination*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse determination* and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the *member* upon request.

Appeals
When *we* deny a claim for a treatment or service, a claim for plan benefits the *member* has already received (*post-service claim* denial) or *we* deny the *member's* request to authorize treatment or service (pre-service denial), *our* decision is known as an *adverse determination*. The *member*, their *physician* or *authorized representative* can request an *appeal* of *our* decision. If *we* rescind the *member's* coverage or deny the *member's* application for coverage, the *member*, their *physician* or *authorized representative* may also *appeal our* decision. When *we* receive an *appeal*, *we* are required to review *our* own decision.

Filing an Appeal
Appeals must be filed in writing by completing the *Grievance* and *Appeal* Form from our website or sending a written *appeal* along with copies of any supporting documents and mailed or faxed to:

Ambetter from Louisiana Health Care Connections
PO Box 10341
Van Nuys, CA 91410
1-833-886-7956

Time Limits for filing an appeal
The *member* or *authorized representative* must file the internal *appeal* within 180 calendar days of the receipt of the notice of denial (an *adverse determination*). Failure to file within this time limit may result in the company's declining to consider the *appeal*.

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

An eligible appellant is:
1. A *member;*
2. Person authorized to act on behalf of the *member*. **Note:** Written *authorization* is required;
3. In the event the *member* is unable to give consent: a *spouse*, family member, or the treating *provider*; or
4. In the event of an *expedited appeal*: the person for whom the insured has verbally given *authorization* to represent the appellant.

Acknowledgement:
Within 5 business days of receipt of an *appeal*, a written acknowledgment to the *member*, the *provider* or the *member's authorized representative* confirming receipt of the *appeal* must be delivered or deposited in the mail.

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

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

Resolution Timeframes:
Appeals will be resolved and we will notify the *member* in writing with the *appeal* decision within the following timeframes:

1. *Post-service claim*: within 60 calendar days after receipt of the request for internal *appeal*; or
2. *Pre-service claim*: within 30 calendar days after receipt of the request for internal *appeal*.

In general, Ambetter of Louisiana Healthcare Connections may seek *member's approval* to extend the time

for providing a decision for 14 calendar days after the expiration of the initial period, or if the plan determines that such an extension is necessary for reasons beyond the control of the plan. There is no provision for extensions in the case of claims involving urgent care or *expedited appeals*.

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

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

Expedited Appeal
An *expedited appeal* may be submitted orally or in writing. If submitted orally, the request must be followed by a brief written appeal. All necessary information, including *our* determination on review, will be transmitted between the *member* and *us* by telephone, facsimile, or other available similarly expeditious method. An *expedited appeal* shall be resolved as expeditiously as the *member's* health condition requires, but not more than 72 hours after receipt of the *appeal*.

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

If the *expedited appeal* involves an *adverse determination* with respect to a concurrent review of an urgent care request, the service shall be continued until the *covered person* or *covered person's authorized representative* has been notified of the determination or until the healthcare *provider* determines that the urgent care is no longer appropriate or necessary. This does not apply to requests for extensions.

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

Simultaneous *expedited appeal* and external review
The *member* or *authorized representative*, may request an *expedited appeal* and an expedited external review (see External Review provision) if both the following apply:

1. The *member* filed a request for an *expedited appeal*; and
2. After a *final adverse determination*, if any of the following apply:
    a. The *member's* treating *physician* certifies that the *adverse determination* involves a medical condition that could seriously jeopardize the *member's life or health*, or would jeopardize

the *member's* ability to regain maximum function, if treated after the timeframe of a standard external review;

b. The *final adverse determination* concerns an admission, availability of care, continued stay or health care service for which the *member* received emergency services, but has not yet been discharged from a facility.
c. The *final adverse determination* involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the *covered person's* treating *physician* certifies in writing that any delay in appealing the *adverse determination* may pose an imminent threat to the *covered person's* health, including but not limited to severe pain, potential *loss* of life, limb, or major bodily function, or the immediate deterioration of the health of the *covered person*.

Right to Participate
A *member* or the *member's authorized representative*, who has filed an *appeal* has the right to submit written comments, documents, records and other information to the Grievances and Appeals Department. The *member* or *member's authorized representative* is entitled to request a copy of the documentation reviewed by the Grievances and Appeals Department in making its determination. The *member* must submit questions or comments to the Grievances and Appeals Department in writing within a period of time provided in the notice to the *member* of the *appeals* process.

Continuing Coverage
The plan cannot terminate a *member's* benefits until the *member's appeal* rights have been exhausted. However, if the plan's decision is ultimately upheld, the *member* may be responsible to pay any outstanding claims or reimburse the plan for claim payments it made during the time of the *appeals*.

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

Rescission of coverage
If the plan rescinds the *member's* coverage, the *member* may file an *appeal* of that determination. The plan cannot terminate a *member's* benefits until the *member's appeal* rights have been exhausted. Since a *rescission* means that no coverage ever existed, if the plan's decision to rescind is upheld, the *member* will be responsible for payment of all claims for health care services.

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

Written Appeal Response
Appeal response letters will be written in a manner to be understood by the *member* and the notification shall include the specific reasons for the denial, determination, or initiation of disenrollment.

Our written decision (for an *adverse determination appeal*) will include:

1. The disposition of and the specific reason or reasons for the decision in clear terms and the medical rationale for the decision, if applicable
2. Any corrective action taken on the *appeal*;
3. The titles and qualifying credentials of the persons involved in making the decision;
4. A statement of the reviewer's understanding of the issues;
5. Reference to the evidence or documentation used as the basis for the decision

6. Reference to the specific plan or *contract* provision on which the determination is based;
7. A statement that the *member* is entitled to receive, upon request and free of charge, reasonable access to and, copies of all documents, records and other information relevant to the *member's* issue;
8. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the *adverse determination*, either the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the *adverse determination* and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the *member* upon request;
9. If the *adverse determination* is based on *medical necessity* or *experimental treatment* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the *member's* medical circumstances or a statement that such explanation will be provided free of charge upon request;
10. A description of the procedures for obtaining an external review of the *final adverse determination*; and
11. If applicable:
    a. Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse determination*;
    b. The date of service;
    c. The health care *provider's* name;
    d. The claim amount;
    e. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
    f. Ambetter of Lousiana Healthcare Connections' denial code with corresponding meaning;
    g. A description of any standard used, if any, in denying the claim;
    h. A description of the external review procedures, if applicable;
    i. The right to bring a civil action under state or federal law;
    j. A copy of the form that authorizes Ambetter of Louisiana Healthcare Connections to disclose protected health information, if applicable;
    k. That assistance is available by contacting the Louisiana Department of Insurance, if applicable; and
    l. A culturally linguistic statement based upon the *member's* county or state of *residence* that provides for oral translation of the *adverse determination*, if applicable.

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

External Review
An external review decision is binding on *us*. An external review decision is binding on the *member* except to the extent the *member* 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.

Applicability/Eligibility
The external review procedures apply to:
1. Any *hospital* or medical policy or certificate; excluding accident only or disability income only insurance; or
2. Conversion plans.

After exhausting the internal *appeal* process, the *member* has four (4) months to make a written request to the Grievances and Appeals Department for an external review after the date of receipt of *our* internal response.

1. If Ambetter of Louisiana Healthcare Connections has not issued a written decision to the *member* or his *authorized representative* within thirty (30) calendar days following the date the *member* or *authorized representative* files the *appeal* and the *member* or *authorized representative* has not requested or agreed to a delay, the *member* or *authorized representative* may file a request for external review and shall be considered to have exhausted the health insurance issuer's internal claims and appeals process.
2. The internal *appeal* process must be exhausted before the *member* may request an external review unless the *member* files a request for an expedited external review at the same time as an internal *expedited appeal* or *we* either provide a waiver of this requirement or fail to follow the *appeal* process;
3. A *member* may make a request for an expedited external review with the plan at the time the *member* receives:
    a. An *adverse determination* if the determination involves a medical condition of the *member* for which the timeframe for completion of an internal *appeal* would seriously jeopardize the life or health of the *member* or would jeopardize the *member's* ability to regain maximum function and the member has filed a request for an internal *expedited appeal*; and
    b. A *final internal adverse determination*, if the *member* has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the *member* or would jeopardize the *member's* ability to regain maximum function, or if the *final internal adverse determination* concerns an admission, availability of care, continued stay, or health care item or service for which the *member* received *emergency* services, but has not been discharged from a facility; and
4. *Members* may request an expedited external review at the same time the internal *expedited appeal* is requested if:
    a. if the *member* has a medical condition in which the time frame for completion of an expedited review of the *appeal* involving an *adverse determination* would seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function; or
    b. if the *adverse determination* involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the *member's* treating *physician* certifies in writing that any delay in appealing the *adverse determination* may pose an imminent threat to the *member's* health, including but not limited to severe pain, potential *loss* of life, limb, or major bodily function, or the immediate deterioration of the health of the *covered person*.
5. Upon receipt of a request for an expedited external review at the same time the internal *expedited appeal* is requested, the independent review organization conducting the external review will determine whether the *member* is required to complete the expedited *appeal* process with *us* first before it conducts the expedited external review.

An external review is available for *appeals* that involve:

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

External Review Process

1. *We* have five (5) business days (*immediately* for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether all of the following have been met:

a. The individual was a *covered person* at the time the item or service was requested or, in the case of a retrospective review, was a *covered person* in the health benefit plan at the time the health care service was provided;
b. The health care service is the subject of an *adverse determination* or a *final adverse determination*;
c. The *member* has exhausted the internal *appeal* process, unless the *covered person* is not required to exhaust the health insurance issuer's internal claims and appeals process; and
d. The *member* has provided all of the information and forms required to process an external review.

2. Within five (5) business days (*immediately* for expedited) after completion of the preliminary review, *we* will notify the commissioner and the *member* and, if applicable, the *authorized representative* in writing whether:
    a. The request is complete.
    b. The request is eligible for external review.
    c. If the request is not complete, inform the *covered person* and, if applicable, the *authorized representative* what information or materials are needed to make the request complete.
    d. If the request is not eligible for external review, inform the *covered person* and, if applicable, the *authorized representative* the reasons for its ineligibility. The *covered person* and, if applicable, the *authorized representative* may *appeal our* initial determination to the commissioner of insurance.
3. *We* will notify the commissioner when a request is eligible for external review by submitting a request for assignment of an IRO through the Department of Insurance's website. Upon notification, the commissioner shall do the following:
    a. Randomly assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner to conduct the external review and notify *us* of the name of the assigned IRO.
    b. Within one (1) business day, send written notice to the *covered person* and, if applicable, the *authorized representative*, of the request's eligibility and acceptance for external review and the identity and contact information of the assigned IRO. The notice will also state *covered person* and, if applicable, the *authorized representative* may submit in writing to the assigned IRO, within five (5) business days following the date of receipt of the notice, any additional information that the IRO should consider when conducting the external review. The IRO shall be authorized but not required to accept and consider additional information submitted after five (5) business days.
4. Within five (5) business days after the date of assignment of the IRO, *we* must provide the documents and any information considered in making the *adverse determination* to the IRO. **Note:** For expedited, after assignment of the IRO, *we* must provide the documents and any information considered in making the *adverse determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method;
5. If *we* fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the *adverse determination*;
6. Upon receipt of any information submitted by the *member*, the IRO must forward the information to *us* within one (1) business day;
7. Upon receipt of the information, *we* may reconsider *our* determination. If *we* reverse *our adverse determination*, *we* must provide written notice of the decision to the *member* and the IRO within one (1) business day after making such decision. The external review would be considered terminated;
8. Within one (1) business day after making the decision to reverse an *adverse determination* or *final adverse determination*, we will notify the *covered person*, if applicable, the *authorized representative*, the assigned IRO, and the commissioner in writing of *our* decision. The assigned IRO will terminate the external review upon receipt of the notice sent by *us*.
9. Within 45 calendar days for external review requests related to medical necessity determinations or 41 days for external review requests related to services denied as experimental or

investigational (as expeditiously as medical condition or circumstances requires, but in no event more than 72 hours for expedited medical necessity denials and as soon as possible, but no longer than 8 days for expedited experimental or investigational denials) after the date of receipt of the request for an external review by the health plan, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse determination* to the *covered person*, if applicable, the *authorized representative*, the commissioner, and to *us*; and

10. Upon receipt of a notice of a decision by the IRO reversing the *adverse determination* or *final adverse determination*, *we* will *immediately* approve the coverage or payment that was the subject of the *adverse determination* or *final adverse determination.*

Expedited External Review

Ambetter will allow a *member* to make a request for an expedited external review with the plan at the time the *member* receives:

a. An *adverse determination* if both of the following apply:
    i. If the determination involves a medical condition of the *member* for which the timeframe for completion of an internal *expedited appeal* would seriously jeopardize the life or health of the *member* or would jeopardize the *member's* ability to regain maximum function; and
    ii. The *covered person* or *authorized representative* has filed a request for an expedited review for an *appeal* involving an *adverse determination*.
b. A *final adverse determination* if either of the following applies:
    i. The *covered person* has a medical condition in which the time frame for completion of a standard external review would seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function.
    ii. The *final adverse determination* concerns an admission, availability of care, continued stay, or health care service for which the *covered person* received emergency services, but has not been discharged from a facility.

An expedited external review will not be provided for retrospective *adverse determinations* or retrospective *final adverse determinations*.

Members may request assistance with all levels of the *appeal* process from the Louisiana Department of Insurance's office of consumer advocacy. The office of consumer advocacy may be contacted at:

Office of Consumer Advocacy
Louisiana Dept. of Insurance
P. O. Box 94214
Baton Rouge, LA 70804-9214
1-225-342-5900 or 1-800-259-5300

The *member* may also view their *grievance* and *appeal* information in their Member Secure Portal.

General Provisions

Entire Contract
This *policy,* the application, expressing the entire money and other consideration for *coverage*, the *schedule of benefits*, and any amendments or endorsements make up the entire *contract* between *you* and *us.* No agent may:

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

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

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

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

In such event, *we* will give *you* 30 days' advance written notice and will include the reason for *rescission*. *Rescission* could be retroactive to the *effective date* of coverage.

Repayment for Fraud, Misrepresentation or False Information
After three years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim based upon such misstatement. During the first three years a *member* is covered under the *policy*, if a *member* makes a misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *policy* or in filing a claim for *policy* benefits, *we* have the right to demand that *member* pay back to *us* all benefits that *we* provided or paid during the time the *member* was covered under the *policy*.

Change in Premium Amount

1. This *policy* will expire December 31, 2022. This *policy* is renewable at *your* option for the *policy year* beginning January 1, 2023. Any renewal of this *policy* for the *policy year* that begins on January 1, 2023 will be subject to premium changes based on the rates that apply.
2. Except as provided in the following paragraph, we will give you 45 days written notice of a premium change, at your last address shown in our records. Any change in premium will become effective on the date specified in the notice. If you continue to pay your premiums, you show that you accept the change.

3. Premiums are guaranteed for the *policy year*. However, we reserve the right to change premiums more often due to a change in the extent or nature of the risk that was not previously considered in the rate determination process at any time during the life of the policy. This risk includes the addition of a newly *covered person*. Additionally, we reserve the right to change the premium if you request a change in benefits from that which was in force at the time of the last rate determination.
4. If your age was misstated, any amount payable or any indemnity accruing under this Contract will be such as the premium paid would have purchased at the correct age. A clerical error will not void insurance which should be in force nor will it continue insurance which should have ended.
5. If non-tobacco premiums are charged when tobacco premiums should have been charged, we may retroactively adjust the premium and collect the appropriate premium.

Applicable Law and Conforming Policy
This *policy* will be governed and construed according to the laws and regulations of the State of Louisiana except when preempted by federal law. This *policy* is not subject to regulation by any state other than the State of Louisiana. This *policy* will conform to the *Essential Health Benefits* package and requirements. If any provision of this *policy* conflicts with any law of the State of Louisiana or the United States of America that applies, the *policy* will be automatically amended to meet the minimum requirements of the law. Any legal action filed against *us* must be filed in the appropriate court in the State of Louisiana.

Extension of Time Limitations
If any limitation of this policy with respect to giving notice of claim, furnishing *proof of loss*, or bringing any action on this policy is less than that permitted by law of the state, district or territory in which the insured resides at the time this policy is issued, such limitation is hereby extended to agree with the minimum period permitted by such law.

Continuity of Care
You have the right to continuity of care that applies to the following provisions and subject to consent of the treating Provider:
1. If *you* have been diagnosed with a *life-threatening illness*.
2. If *you* have been diagnosed with *serious acute condition*.
3. If *you* have been diagnosed as being in a high-risk *pregnancy* or are past the 24th week of *pregnancy*, *you* can continue receiving *Covered Services* through delivery and postpartum care related to the *pregnancy* and delivery.
4. If *you* are currently within an ongoing course of treatment for a health condition for which a treating *provider* attests that discontinuing care by that *provider* would worsen the condition or interfere with anticipated outcomes.

The provisions of continuity of care do not apply if any of the following occurs:
1. The reason for termination of a *provider*'s contractual agreement is a result of documented reasons relative to quality of care, or the suspension, revocation or applicable restriction of the license to practice in Louisiana by the Louisiana State Board of Medical Examiners.
2. *You* voluntarily choose to change *providers*.
3. *You* move outside of the geographic *service area* of the *provider*.
4. *Your* chronic condition only requires routine monitoring and is not in an acute phase of the condition.

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

We protect all oral, written and electronic PHI. *We* follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. *We* are required to notify *you* about these practices every year. This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. If you need more information or would like the complete notice, please visit https://www.louisianahealthconnect.com/ or call Member Services at 1-866-595-8133 (TTY/TDD 711).

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

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

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de [Health Plan Name], tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al [Health Plan Phone].
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'[Health Plan Name], vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez-le [Health Plan Phone].
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về [Health Plan Name] , 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 [Health Plan Phone].
Chinese:	如果您，或是您正在協助的對象，有關於 [Health Plan Name] 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 [Health Plan Phone]。
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول[Plan Name Health]، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ [Phone Health Plan].
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa [Health Plan Name], may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa [Health Plan Phone].
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 [Health Plan Name]에 관해서 질문이 있다면 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 [Health Plan Phone]번으로 전화하십시오.
Portuguese:	Se você ou alguém que estiver a ajudar tiver dúvidas sobre a [health plan name], tem o direito de obter ajuda e informações no seu idioma gratuitamente. Para falar com um intérprete, ligue para [health plan phone #].
Laotian:	ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ [Health Plan Name], ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ ໃຫ້ໂທຫາ [Health Plan Phone].
Japanese:	Health Plan Name 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、[Health Plan Phone] までお電話ください。
Urdu:	اگر [Health Plan Name] کے بارے میں آپ کے، یا جن کی آپ مدد کر رہے ہیں، ان کے سوالات ہوں تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی مترجم سے بات کرنے کے لیے [Health Plan Phone] پر کال کریں۔
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu [Health Plan Name] 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 [Health Plan Phone] an.
Persian:	اگر شما، یا کسي که به او کمک مي کنید سؤالي در مورد [Name Health Plan] دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. برای صحبت کردن با مترجم با شماره [Health Plan Phone] تماس بگیرید.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования [Health Plan Name] вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону [Health Plan Phone].
Thai:	หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีคำถามเกี่ยวกับ [health plan name] ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข [health plan phone #].

AMB21-LA-C-00599 [Copyright]

Statement of Non-Discrimination

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

Ambetter from Louisiana Healthcare Connections Inc.:

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

If you need these services, contact Ambetter from Louisiana Healthcare Connections Inc. at 1-833-635-0450 (TTY 711).

If you believe that Ambetter from Louisiana Healthcare Connections Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ambetter from Louisiana Healthcare Connections Inc., Attn: Appeals and Grievances PO Box 10341 Van Nuys CA, 91410, 1-833-635-0450 (TTY 711), Fax 1-833-886-7956. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from Louisiana Healthcare Connections Inc. is available to help you. You can also file a civil rights complaint with the U.S Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

Declaración de no discriminación

Ambetter de Louisiana Healthcare Connections cumple con las leyes federales de derechos civiles aplicables y no discrimina en base a raza, color, origen nacional, edad, discapacidad o sexo. Ambetter from Louisiana Healthcare Connections no excluye a las personas ni las trata de manera distinta debido a su raza, color, origen nacional, edad, discapacidad o sexo.

Ambetter de Louisiana Healthcare Connections:

- Ofrece ayudas y servicios gratuitos a personas con discapacidades para que se comuniquen eficazmente con nosotros, como:
  - Intérpretes de lenguaje de señas calificados
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Ofrece servicios gratuitos de idiomas a las personas cuyo idioma principal no es el inglés, tales como:
  - Intérpretes calificados
  - Información escrita en otros idiomas

Si necesita estos servicios, comuníquese con Ambetter de Louisiana Healthcare Connections, 1-833-635-0450 (TTY 711).

Si cree que Ambetter de Louisiana Healthcare Connections no le ha brindado estos servicios o le ha discriminado de otra manera por motivos de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja ante: Ambetter from Louisiana Healthcare Connections, Appeals and Grievances, PO Box 10341 Van Nuys CA, 91410, 1-833-635-0450 (TTY 711), Fax 1-833-886-7956. Usted puede presentar una queja por correo, fax, o por correo electrónico. Si necesita ayuda para presentar una queja, Ambetter from Louisiana Healthcare Connections está disponible para usted. Además puede presentar un reclamo de derechos civiles al U.S. Department of Health and Human Services (Departamento de Salud y Servicios Humanos de EE.UU.), Office for Civil Rights (Oficina de Derechos Civiles) electrónicamente a través del Portal para reclamos de la Oficina de Derechos Civiles, disponible en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* o por correo o teléfono en: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD).

Los formularios de reclamo están disponibles en *http://www.hhs.gov/ocr/office/file/index.html.*

2022 Evidence of Coverage

https://www.louisianahealthconnect.com/

Ambetter from Louisiana Healthcare Connections

Home Office: 8585 Archives Avenue, Suite 310, Baton Rouge, LA 70809

Major Medical Expense Insurance Policy

In this *policy,* the terms *"you"*, *"your"*, or *"yours"* will refer to the *member* or any *dependents* named on the *Schedule of Benefits*. The terms *"we," "our,"* or *"us"* will refer to **Louisiana Healthcare Connections** or **Ambetter from Louisiana Healthcare Connections**.

AGREEMENT AND CONSIDERATION

This document along with the corresponding *Schedule of Benefits* is *your* contract and 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 health care benefits to *you*, the *member*, for *covered services* as outlined in this *policy*. Benefits are subject to *policy* definitions, provisions, limitations, and exclusions.

GUARANTEED RENEWABLE

Guaranteed renewable means that this contract will renew each year on the anniversary date unless terminated earlier in accordance with *policy* terms. *You* may keep this *policy* in force by timely payment of the required premiums. However, *we* may decide not to renew the *policy* as of the renewal date if: (1) *we* decide not to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where *you* then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *policy* benefits.

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

At least 60 days' notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *policy* or a change in a *member's* health. While this *policy* is in force, *we* will not restrict coverage already in force. If *we* discontinue offering and decide not to renew all polices issued on this form, with the same type and level of benefits, for all residents of the state where *you* reside, *we* will provide a written notice to *you* at least 90 days prior to the date that *we* discontinue coverage.

This *policy* contains *prior authorization* requirements. *You* may be required to obtain a referral from a *primary care physician* in order to receive care from a *specialist provider*. Benefits may be reduced or not covered if the requirements are not met. Please refer to the *Schedule of Benefits* and the Prior Authorization section.

This *policy* takes effect at 12:01 a.m. of the date on which the *member*'s coverage begins and terminates at 11:59 pm on the last day of the month for which premiums were paid and the date that the *member*'s coverage ends.

NOTICE: HEALTH CARE SERVICES MAY BE PROVIDED TO *YOU* AT A *NETWORK* HEALTH CARE FACILITY BY FACILITY-BASED *PHYSICIANS* WHO ARE NOT IN *YOUR* HEALTH PLAN. *YOU* MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-*NETWORK* SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR *COPAYMENTS*, *COINSURANCE*,

***DEDUCTIBLES*, AND NON-*COVERED SERVICES*. SPECIFIC INFORMATION ABOUT IN-*NETWORK* AND OUT-OF- *NETWORK* FACILITY-BASED *PHYSICIANS* CAN BE FOUND AT *OUR* WEBSITE HTTPS://WWW.LOUISIANAHEALTHCONNECT.COM/ OR CALLING *US* AT 1-866-595-8133 (TTY/TDD 711).**

NOTICE: *YOUR* SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN *YOUR* HEALTH PLAN AND *YOUR* PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW *YOUR* PROVIDER TO BILL *YOU* FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

TEN DAY RIGHT TO RETURN *POLICY*

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

Louisiana Healthcare Connections

Jamie Schlottman
CEO and Plan President

TABLE OF CONTENTS

Introduction

Welcome to Ambetter from Louisiana Healthcare Connections! This *policy* has been prepared by *us* to help explain *your* coverage. Please refer to this *policy* whenever *you* require medical services.
It describes:

- How to access medical care.
- What health services are covered by *us*.
- What portion of the health care costs *you* will be required to pay.

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

This *policy* should be read in its entirety. Since many of the provisions are interrelated, *you* should read the entire *policy* to get a full understanding of *your* coverage. Many words used in the *policy* have special meanings: these words are *italicized* and are defined for *you* in the Definitions section. This *policy* also contains exclusions, so please be sure to read this *policy* carefully.

How to Contact *Us*
Ambetter from Louisiana Healthcare Connections
8585 Archives Avenue, Suite 310
Baton Rouge, LA 70809

Normal Business Hours of Operation 7:00 a.m. to 7:00 p.m.

Member Services	1-866-595-8133
TDD/TTY line	711
Fax	1-866-768-9374
Emergency	**911**

24/7 Nurse Advice Line 1-866-595-8133 or for the hearing impaired (TDD/TTY 711)

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

Our interpreter services are provided at no cost to *you*. *We* have representatives that speak Spanish and medical interpreters to assist with other languages. *Members* who are blind or visually impaired and need help with interpretation can call *Member* Services for an oral interpretation.

To arrange for interpreter services, please call *Member* Services at 1-866-595-8133 (TTY/TDD 711).

Member Rights and Responsibilities

We are committed to:

7. Recognizing and respecting *you* as a *member*.
8. Encouraging open discussions between *you*, *your physician,* and *medical practitioners*.
9. Providing information to help *you* become an informed health care consumer.
10. Providing access to *covered services* and *our network providers*.
11. Sharing *our* expectations of *you* as a *member*.
12. Providing coverage regardless of age, ethnicity or race, religion, gender, sexual orientation, national origin, physical or mental disability, or expected health or genetic status.

If *you* have difficulty locating a primary care *provider*, specialist, *hospital* or other contracted *provider* please contact *us* so that *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:

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

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

37. A current list of *network providers*.
38. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
39. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin, or religion.
40. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
41. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
42. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *primary care physician*'s instructions are not followed. *You* should discuss all concerns about treatment with *your primary care physician*. *Your primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
43. Select *your primary care physician* within the *network*. *You* also have the right to change *your primary care physician* or request information on *network providers* close to *your* home or work.
44. Know the name and job title of people giving *you* care. *You* also have the right to know which *physician* is *your primary care physician*.
45. An interpreter when *you* do not speak or understand the language of the area.
46. A second opinion by a *network physician*, at no cost to *you*, if *you* believe *your network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
47. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it.
48. Advance directives are forms *you* can complete to protect *your* rights for medical care. It can help *your primary care physician* 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:

18. Read this *policy* in its entirety.
19. Treat all health care professionals and staff with courtesy and respect.
20. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of *your physician* until *you* understand the care *you* are receiving.
21. Review and understand the information *you* receive about *us. You* need to know the proper use of *covered services*.
22. Show *your* ID card and keep scheduled appointments with *your physician*, and call the *physician's* office during office hours whenever possible if *you* have a delay or cancellation.
23. Know the name of *your* assigned *primary care physician*. *You* should establish a relationship with *your physician*. *You* may change *your primary care physician* verbally or in writing by contacting *Member* Services.
24. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
25. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.

26. Supply, to the extent possible, information that *we* or *your* health care professionals and *physicians* need in order to provide care.
27. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
28. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with *your primary care physician* 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.
29. Follow all health benefit plan guidelines, provisions, policies, and procedures.
30. Use any emergency room only when *you* think *you* have a medical *emergency*. For all other care, *you* should call *your primary care physician*.
31. When *you* enroll in this coverage, give all information about any other medical coverage *you* have. If, at any time, *you* get other medical coverage besides this coverage, *you* must tell *us*.
32. Pay *your* monthly premiums on time and pay all *deductible amounts, copayment amounts*, or *cost sharing percentages* at the time of service.
33. Inform the entity in which *you* enrolled for this *policy* if *you* have any changes to *your* name, address, or family members covered under this *policy* within 60 days from the date of the event.
34. 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*.

Important Information

Provider Directory
A listing of *network providers* is available online at https://findaprovider.louisianahealthconnect.com/location/. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* with *your* healthcare services. *You* may find any of *our network providers* by completing the "Find a Provider" function on *our* website and selecting the Ambetter *Network*. There *you* will have the ability to narrow *your* search by *provider* specialty, zip code, gender, language spoken and whether or not they are currently accepting new patients. *Your* search will produce a list of *providers* based on *your* search criteria and will give *you* other information such as name, address, phone number, office hours, specialty and board certifications.

At any time, *you* can request a copy of the provider directory at no charge by calling *Member* Services at 1-866-595-8133 (TTY/TDD 711). In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. We* can also help *you* pick a *primary care physician* (*PCP*). *We* can make *your* choice of *primary care physician* effective on the next business day.

Call the *primary care physician*'s office if *you* want to make an appointment. If *you* need help, call *Member* Services at 1-866-595-8133 (TTY/TDD 711). *We* will help *you* make the appointment.

Member ID Card
When *you* enroll, *we* will mail *you* a *member* ID card after *we* receive *your* completed enrollment material and *you* have paid *your* initial premium payment. This card is proof that *you* are enrolled in the Ambetter plan. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under the *policy*. The ID card will show *your* name, *member* ID number, the phone numbers for *Member* Services, pharmacy and 24/7 Nurse Advice Line and *copayment amounts* required at the time of service. If *you* do not get *your* ID card within a few weeks after *you* enroll, please call *Member* Services at 1-866-595-8133 (TTY/TDD 711). *We* will send *you* another card.

The ID card will show *your* name, *member* ID#, and *copayment amounts* required at the time of service. If *you* do not get *your* ID card within a few weeks after *you* enroll, please call *Member* Services at 1-866-595-8133 (TTY/TDD 711). *We* will send *you* another card.

Website
Our website helps *you* get the answers to 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 https://www.louisianahealthconnect.com/. It also gives *you* information on *your* benefits and services such as:

11. Finding a *network provider*.
12. Locate other *providers* (e.g., *hospitals* and pharmacies).
13. *Our* programs and services, including programs to help *you* get and stay healthy.
14. A secure portal for *you* to check the status of *your* claims, make payments, and obtain a copy of *your member* ID card.
15. *Member* Rights and Responsibilities.
16. Notice of Privacy Practices.
17. Current events and news.
18. *Our* Formulary or Preferred Drug List.
19. *Deductible* and *copayment* accumulators.
20. Selecting a *Primary Care Provider*.

Quality Improvement

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

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

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

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

Definitions

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

Wherever used in this *policy*:

Acute rehabilitation means *rehabilitation* for patients who will benefit from an intensive, multidisciplinary *rehabilitation* program. Patients normally received 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*.

Adverse determination means any of the following:

a. A determination by a health insurance issuer or its designee *utilization review* organization that, based upon the information provided, a request for a benefit under the health insurance issuer's health benefit plan upon application of any *utilization review* technique does not meet the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be *experimental or investigational* and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.
b. The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health insurance issuer or its designee *utilization review* organization of a *covered person's* eligibility to participate in the health insurance issuer's health benefit plan.
c. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit under a health benefit plan.
d. A *rescission of coverage* determination.

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

Allowed amount (also see **"*Eligible Service Expense*"**) means the maximum amount *we* will pay a *provider* for a *covered service*. When a *covered service* is received from a *network provider*, the *allowed amount* is the amount the *provider* agreed to accept from *us* as payment for that particular service. In all cases, the *allowed amount* will be subject to *cost sharing* (e.g., *deductible*, *coinsurance* and *copayment*) per the *member's* benefits. This amount excludes any payments made to the *provider* by *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. However, *you* will not be responsible for *balance billing* for unanticipated 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 *non-network facility* for *emergency services* or air ambulance services. This is known as *balance billing* – 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.

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

Applied behavioral analysis or ***ABA*** means the application 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 *medically necessity* or appropriateness of care for a *member* by the *member's PCP* or *provider*. *Authorizations* are not a guarantee of payment.

Authorized representative means any of the following:

a. A person to whom a *covered person* has given express written consent to represent the *covered person*. It may also include the *covered person's* treating provider if the *covered person* appoints the provider as his *authorized representative* and the provider waives in writing any right to payment from the *covered person* other than any applicable *copayment* or other *coinsurance* amount. In the event that the service is determined not to be medically necessary, and the *covered person* or his *authorized representatives*, except for the *covered person's* treating health care professional, thereafter requests the services, nothing shall prohibit the provider from charging usual and customary charges for all non-medically necessary services provided.
b. A person authorized by law to provide substituted consent for a *covered person*.
c. An *immediate family* member of the *covered person* or the *covered person's* treating health care professional when the *covered person* is unable to provide consent.
d. In the case of an urgent care request, a health care professional with knowledge of the *covered person*'s medical condition.

Autism spectrum disorder means as defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* 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 ever 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.

Beneficiary means a person designated by a participant, or by the terms of a health insurance benefit plan, who is or may become entitled to a benefit under the plan.

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

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

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

Care management 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 when mutually agreed to by *us*, the *member* and the *member's provider*.

Center of Excellence means a *hospital* that:

3. Specializes in a specific type or types of *listed transplants* or other services such as cancer, bariatric, or infertility; and
4. Has agreed with *us* or an entity designated by *us* to meet quality of care criteria on a cost efficient basis. The fact that a *hospital* is a *network provider* does not mean it is a *Center of Excellence.*

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

Cleft Lip and Cleft Palate Services means preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.

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:

3. Conditions whose diagnoses are distinct from *pregnancy*, but are adversely affected by *pregnancy* or are caused by *pregnancy* and not, from a medical viewpoint, associated with a normal *pregnancy*. This includes: ectopic *pregnancy*, spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, *physician* prescribed rest during the period of *pregnancy*, morning sickness, and conditions of comparable severity associated with management of a difficult *pregnancy*, and not constituting a medically classifiable distinct complication of *pregnancy*.
4. 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*.

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

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

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

4. Provided or incurred while the *member's* coverage is in force under this *policy*;
5. Covered by a specific benefit provision of this *policy*; and
6. Not excluded anywhere in this *policy*.

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

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

Credible coverage means coverage of an individual under (a) A group health plan; (b) Health insurance coverage; (c) Medicare coverage; (d) Medicaid; (e) Medical Insurance coverage under the General Military Law; (f) A medical care program of the Indian Health Service of a tribal organization; (g) A state health benefits risk pool; (h) A health plan offered for federal employees; (i) A public health plan; or (j) A health benefit plan provided to members of the Peace Corps. Such term does not include coverage consisting solely of coverage of excepted benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

8. A natural child;
9. A legally adopted child;
10. A child placed with *you* for adoption;
11. A child for whom legal guardianship has been awarded to *you* or *your spouse*; or
12. A stepchild;
13. A grandchild residing with *you,* provided *you* have been granted legal custody or provisional custody by mandate of the grandchild; or
14. An unmarried child who is placed in the home of an insured following execution of an act of voluntary surrender in favor of *you* or *your* legal representative, for whom the date after which the act of voluntary surrender becomes irrevocable has passed.

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

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

3. For *network providers*: When a *covered service* is received from a *network provider*, the *eligible service expense* is the contracted fee with that *provider*.
4. For *non-network providers*, unless otherwise required by Federal or Louisiana 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, if any, that has been mutually agreed upon by *us* and the *provider* as payment in full. However, if the *provider* has not agreed to accept a negotiated fee with *us* as payment in full, the *eligible service expense* is the median contracted amount paid to *network providers* for the same *covered service*. *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.

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. *Member cost share* will be calculated from the recognized amount based upon 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 an anesthesiologist, pathologist or a radiologist 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. However, if the *provider* has not agreed to accept a negotiated fee with *us* as payment in full, the *eligible service expense* is the median contracted amount paid to *network providers* for the same *covered service*. *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* professional *provider,* excluding those providers outlined in 2(c) above, 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* is reimbursement as determined by *us* and as required by applicable law. Unless *you* receive and sign the necessary written notice and consent document under federal 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. *Member cost share* will be calculated from the recognized amount based upon applicable law. If *you* are balance billed in these situations, please contact *Member* Services *immediately* at the number listed on the back of *your* ID card.

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: (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. In addition to applicable *cost sharing*, *you* may *be balance billed* for these services.

Emergency medical condition is a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in:

d. Placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy;
e. Serious impairment to bodily function;
f. Serious dysfunction of any bodily organ or part.

Emergency medical services are those medical services necessary to screen, evaluate, and stabilize an *emergency medical condition*.

Enrollee means an individual who is enrolled in a health maintenance organization.

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

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

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

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

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

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

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

7. Is licensed as a *hospital*, *extended care facility*, or *rehabilitation facility* by the state in which it operates;
8. 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;
9. Maintains a daily record on each patient;
10. Has an effective *utilization review* plan;
11. Provides each patient with a planned program of observation prescribed by a *physician*; and
12. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing *generally accepted standards of medical practice* for that condition.

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

Final adverse determination means an *adverse determination*, including medical judgment, involving a covered benefit that has been upheld by a health insurance issuer, or its designee *utilization review* organization, at the completion of the health insurance issuer's internal claims and *appeals* process procedures provided pursuant to R.S. 22:2401.

Follow-up care is not considered emergency care. Benefits are provided for treatment of *emergency medical conditions* and *emergency* screening and stabilization services without *prior authorization*. Benefits for *emergency* care include facility costs and *physician* services, and supplies and *prescription drugs* charged by that facility. *You* must notify *us* or verify that *your physician* has notified *us* of *your* admission to a *hospital* within 48 hours or as soon as possible within a reasonable period of time. When *we* are contacted, *you* will be notified whether the *inpatient* setting is appropriate, and if appropriate, the number of days considered *medically necessary*. By contacting *us*, *you* may avoid financial responsibility for any *inpatient* care that is determined to be not *medically necessary* under *your* Plan. If *your provider* does not contract with *us*, *you* will be financially responsible for any care *we* determine is not *medically necessary*. Care and treatment provided once *you* are *medically stabilized* is no longer considered *emergency* care. Continuation of care from a non-participating *provider* beyond that needed to evaluate or stabilize *your* condition in an *emergency* will be covered as a non-*network* service unless *we authorize* the continuation of care and it is *medically necessary*.

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

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

Grievance means, in a health insurance issuer's internal claims and *appeals* process, a written *complaint* or oral *complaint*, if the *complaint* involves an urgent care request submitted by or on behalf of a *covered person* regarding any of the following:

a. Availability, delivery, or quality of health care services, including a *complaint* regarding an *adverse determination* made pursuant to *utilization review*.
b. Claims payment, handling, or reimbursement for health care services.
c. Matters pertaining to the contractual relationship between a *covered person* and a health insurance issuer.

Habilitation or ***habilitation services*** means health care services that help *you* 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* or outpatient settings.

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

Home health aide services means those services provided by a home health aide employed by a *home 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:

3. Provided by a *home health care agency*; and
4. Prescribed and supervised by a *physician*.

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

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

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

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

Hospital means an institution that:

7. Operates as a *hospital* pursuant to law;
8. Operates primarily for the reception, care, and treatment of sick or injured persons as *inpatients*;
9. Provides 24-hour nursing service by registered nurses on duty or call;
10. Has staff of one or more *physicians* available at all times;
11. 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
12. 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 place for the aged, drug addicts, alcoholics, or runaways; a facility for wilderness or outdoor programs; or a similar establishment.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *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 be deemed not to be confined in a *hospital* for purposes of this *policy*.

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

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

Immediately means as expeditiously as the medical situation of the *covered person* requires but in no event longer than one day for expedited reviews or one business day for standard reviews.

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

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

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

Life-threatening illness means a severe, serious, or acute condition for which death is probable.

Listed transplant means one of the following procedures:

7. Heart transplants.
8. Lung transplants.
9. Heart/lung transplants.
10. Kidney transplants.
11. Liver transplants.
12. Bone marrow transplants for the following conditions, including, but not limited to:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma.
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma.
    c. *BMT* for Severe Aplastic Anemia.
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia.
    e. *BMT* for Chronic Myelogenous Leukemia.
    f. *ABMT* for Testicular Cancer.
    g. *BMT* for Severe Combined Immunodeficiency.
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma.
    i. *BMT* for Myelodysplastic Syndrome.
    j. *BMT* for Wiskott-Aldrich Syndrome.
    k. *BMT* for Thalassemia Major.
    l. *BMT* or *ABMT* for Multiple Myeloma.
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma.
    n. *BMT* for Fanconi's anemia.
    o. *BMT* for malignant histiocytic disorders.
    p. *BMT* for juvenile myelomonocytic leukemia (JMML).

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

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

8. *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;
9. 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);
10. 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;
11. A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits;
12. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 54.9802-1(d)) that includes the individual;
13. 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
14. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

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

Maximum out-of-pocket amount is the sum of the *deductible amount*, *prescription drug deductible amount* (if applicable), *copayment amount,* and *coinsurance* percentage of *covered expenses*, as shown in the *Schedule of Benefits*. After the *maximum out-of-pocket amount* is met for an individual, *we* pay 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:

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

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

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

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

Medical practitioner includes but is not limited to a *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.

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

9. Is consistent with the symptoms or diagnosis;
10. Is provided according to *generally accepted standards of medical practice*;
11. Is not *custodial care*;
12. Is not solely for the convenience of the *physician* or the *member*;
13. Is not *experimental* or *investigational*;
14. Is provided in the most cost effective care facility or setting;
15. 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
16. 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 stabilized means that the person is no longer experiencing further deterioration as a result of a prior *injury* or *illness* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*.

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

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

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

Necessary medical supplies means medical supplies that are:

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

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

Network means a group of *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* health services even if provided by a *non-network provider*.

Network provider means any person or entity that has entered into a contract with Ambetter from Louisiana Healthcare Connections 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*.

Newly Born means infants from the time of birth until age one month or until such time as the infant is well enough to be discharged from a *hospital* or neonatal special care unit to his home, whichever period is longer.

Non-elective caesarean section means:

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

Non-network provider means a *medical practitioner, 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 not *covered*, except as specifically stated in this *policy*.

Orthotic device means a *medically necessary* custom fabricated brace or support that is designed as a component of a *prosthetic device*.

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

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

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

Pain management program means a program using interdisciplinary teams providing coordinated, goal-oriented services to a *covered person* who has chronic pain that significantly interferes with physical, psychosocial, and vocational functioning, for the purpose of reducing pain, improving function, and

decreasing dependence on the health care system. A *pain management program* must be individualized and provide physical *rehabilitation*, education on pain, relaxation training, and medical evaluation.

Period of extended loss means a period of consecutive days:

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

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

Placement or ***being placed***, for adoption, in connection with any *placement* for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's *placement* with such person terminates upon the termination of such legal obligation.

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

Policy Year is the 12-month *calendar year* beginning at 12:00 a.m. on January 1 and ending at 11:59 p.m. on December 31.

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.

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

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

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

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

Primary care physician or ***PCP*** means a *physician* who is a family practitioner, general practitioner, pediatrician, or internist.

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

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

Prosthetic device means an artificial leg or arm.

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

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

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

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

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

3. Is licensed by the state as a *rehabilitation facility*; and
4. 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 coverage means a cancellation or discontinuance of coverage that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:

3. The cancellation or discontinuance of coverage has only a prospective effect; or
4. The cancellation or discontinuance of coverage 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 that provides (with or without charge) sleeping accommodations, and:

3. Is not a *hospital, extended care facility,* or *rehabilitation facility*; or
4. 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 acute condition means a disease or condition requiring complex ongoing care which the *Member* is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits.

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 parishes, where *we* have been authorized by the State of Louisiana 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* health care services and supplies. *You* can receive precise *service area* boundaries from *our* website or *Member* Services.

Social determinants of health means 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 physician means a *physician* who is not a *primary care physician.*

Specialist provider means 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.

Spouse means *your* lawful wife or husband.

Subscriber means the person who is responsible for payment to a health maintenance organization or whose employment or other status, except for family dependence, is the basis for eligibility for enrollment in the health maintenance organization.

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

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

3. An invasive diagnostic procedure; or
4. 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.

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

Surveillance tests for ovarian cancer means annual screening using:

4. CA-125 serum tumor marker testing;
5. Transvaginal ultrasound; or
6. Pelvic examination.

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

Telemedicine services means health care services delivered by use of interactive audio, video, or other electronic media, including the following:

3. Medical exams and consultations; and,
4. *Behavioral health*, including *substance abuse* evaluations and treatment.

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

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

Temporarily Medically Disabled Mother means a woman who has recently given birth and whose *physician* has advised that normal travel would be hazardous to her health.

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 *policy* was completed by the *member*, including all tobacco and nicotine products, e-cigarettes or vaping devices, but excluding religious and ceremonial uses of tobacco.

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

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

3. *"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.
4. *"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:

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

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

Dependent Member Coverage

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

5. The date *you* became covered under this *policy*;
6. The date of marriage to add a *spouse*;
7. The date of an eligible newborn's birth; or
8. The date that an adopted child is placed with *you* or *your spouse* for the purposes of adoption or *you* or *your spouse* assumes total or partial financial support of the child.

Effective Date for Initial Dependent Members
The *effective date* for *your* initial *dependent members,* if any, is shown on the *Schedule of Benefits*. Only *dependent members* included in the application for this *policy* will be covered on *your effective date*.

Dependent Medical Leave of Absence
Coverage will continue for a *dependent member* college student who takes a medical leave of absence or reduces his or her course load to part-time status because of a catastrophic *illness* or *injury*. Continuation of coverage for such a *dependent member* college student will automatically terminate 12 months after notice of the *illness* or *injury* or until coverage would have otherwise lapsed pursuant to the terms and conditions of this *contract*, whichever comes first, provided the need for part-time status or medical leave of absence is supported by a clinical certification of need from a *physician* licensed to practice medicine in all its branches.

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

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

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

The child will be covered for *loss* due to *injury* and *illness* including *medically 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. 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 within 60 days of the birth or *placement* and b) any additional premium required for the addition of the child within 90 days of the date of *placement.*

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

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

Ongoing Eligibility

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

8. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *policy*;
9. The date a *member's* employer and a *member* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes;
10. The primary *member* residing outside the *service area* or moving permanently outside the *service area* of this plan;
11. The date *we* receive a request from *you* to terminate this contract, or any later date stated in *your* request;
12. 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;
13. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact (e.g. the date that a *member* accepts any direct or indirect contributions or reimbursement by or on behalf of an employer, for any portion of the premium for coverage under this contract); or
14. The date of a *member's* death.

If *you* have material modifications (examples include a change in life event such as marriage, death, or other change in family status), or questions related to *your* health insurance coverage, contact *Member* Services at 1-866-595-8133 (TTY/TDD 711).

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

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

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

You must furnish *us* with periodic proof of continuing incapacity and dependency within thirty-one (31) days of the child's 26th birthday. *We* may require subsequent proof once a year after the initial two-year period following the child's 26th birthday.

Open Enrollment
Each year there will be an open enrollment period for coverage. 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.

Special Enrollment Periods
In general, a *qualified individual* has 60 days to report certain life changes, known as "qualifying events" to the plan or by using Ambetter's Enrollment Platform. *Qualified Individuals* may be granted a Special Enrollment Period where they may enroll in or change to a different 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'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 applicable state authority or *us*;
4. An *enrollee* or *dependent* adequately demonstrates to the applicable state authority or *us* that the plan in which he or she is enrolled substantially violated a material provision of its *contract* in relation to the *enrollee*;
5. 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;
6. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
7. 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;
8. 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;
9. 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); or
10. 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.

If *you* have or believe *you* have experienced a qualifying event (common examples include a change in life event such as marriage, death or other change in family status), contact *Member* Services at 1-866-595-8133 (TYY/TDD 711).

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. A *subscriber* may enroll an unborn natural child prior to birth, however, coverage will not be effective until the date of birth.

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.

Premiums

Premium Payment
Each premium is to be paid on or before its due date. The initial premium must be paid prior to the coverage *effective date*, although an extension may be provided during the annual Open Enrollment period. Any past due premium payments for coverage provided will be due at the beginning of the new plan year in addition to current premium changes. New coverage will not be effective until all such payments are made.

Grace Period
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 30 day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *policy* will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. *We* will mail *you* a notice of non-payment fifteen days prior to the end of *your* grace period.

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

5. Ryan White HIV/AIDS program under Title XXVI of the Public Health Service Act;
6. Indian tribes, tribal organizations, or urban Indian organizations;
7. State and Federal government programs; or
8. Family members.

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

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

Misstatement of Age
If a *member's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

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

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

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

Prior Authorization

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

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

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

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

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

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

6. At least 5 days prior to an elective admission as an *inpatient* in a *hospital*, *extended care* or *rehabilitation facility*, or *hospice* facility.
7. At least 30 days prior to the initial evaluation for organ transplant services.
8. At least 30 days prior to receiving clinical trial services.
9. Within 24 hours of an admission for *inpatient* mental health or *substance abuse* treatment.
10. At least 5 days prior to the start of *home health care*.

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

6. For immediate request situations, within 1 business day, when the lack of treatment may result in an emergency room visit or *emergency* admission.
7. For urgent concurrent reviews within 24 hours of receipt of the request.
8. For urgent *pre-service* reviews, within 72 hours from date of receipt of request.
9. For non-urgent *pre-service* reviews within 5 days, but no longer than 15 days, of receipt of the request.
10. For post-service or retrospective reviews, within 30 calendar days of receipt of the request.

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

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

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

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

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

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

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

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

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

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 *prior authorization* for *you* to obtain services from a *non-network provider* at no greater cost to *you* than if *you* went to a *network provider*. If *covered services* are not available from a *network provider, you* or *your* primary care provider must request *prior authorization* from *us* before *you* may receive services from a *non-network provider*. Otherwise, *you* will be responsible for all charges incurred.

Hospital Based Providers
When receiving care at an Ambetter participating *hospital* it is possible that some *hospital*-based *providers* (for example, anesthesiologists, radiologists, pathologists) may not be under contract with Ambetter as participating *providers*. *We* encourage *you* to inquire about the *providers* who will be treating *you* before *you* begin *your* treatment, so *you* can understand their participation status with Ambetter. *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.

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

Cost Sharing Features

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

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

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

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

Deductible
The *deductible amount* means the amount of *covered service expenses* that must be paid by each/all *members* before any benefits are provided or payable. The *deductible 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 *member*'s *eligible service expenses*.

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

The amount provided or payable will be subject to:
3. Any specific benefit limits stated in the *policy*; and
4. A determination of *eligible service expenses*.

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

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

Access to Care

Primary Care Provider
In order to obtain benefits, *you* must designate a *network primary care physician* 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 physician* who is accepting new patients from any of the following *provider* types:

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

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

You may obtain a list of *network primary care providers* at *our* website and using the "Find a Provider" function or by calling the telephone number shown on the front page of this contract. *You* should get to know *your PCP* and establish a healthy relationship with them. *Your PCP* will:

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

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

Your network primary care physician 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 physician* for obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist. *You* have direct access to qualified obstetric and gynecological care.

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 1-866-595-8133 (TTY/TDD 711). A licensed nurse is always available and ready to answer *your* health questions. In an emergency, call 911 or head straight to the nearest emergency room.

Changing *Your* Primary Care Physician (PCP)
You may change *your network primary care physician* for any reason, but not more frequently than once a month, by submitting a written request, online at *our* website at https://www.louisianahealthconnect.com/, or by contacting *our* office at the number shown on *your* identification card. The change to *your network primary care physician* of record will be effective no later than 30 days from the date *we* receive *your* request.

Referral Required For Maximum Benefits
You do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians, you* may be required to obtain a referral from *your network primary care physician* for benefits to be payable under *your policy* or benefits payable under this *policy* may be reduced. Please refer to the *Schedule of Benefits*.

Network Availability
Your network is subject to change. The most current *network* may be found online at *our* website or by contacting *us* at the number shown on *your* identification card. A *network* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, please contact *Member* Services prior to moving. Note that services from *non-network providers* are not *covered services* under this agreement but *you* may have the opportunity to disenroll from coverage under this contract and enroll in a different health plan with a *network* in that area. If *you* receive non-*emergency services* from *non-network providers*, benefits will be calculated in accordance with the terms of this contract for *non-network providers*.

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

Non-Emergency Services
If *you* are traveling outside of the Louisiana *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 Louisiana by searching the relevant state in *our* provider directory at 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.

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 to the nearest emergency room. Be sure to a call *us* and report *your emergency* within one business day. *You* do not need prior *approval* for *emergency* care services. Payments of claims for *emergency medical services* rendered by a *non-network provider* are not made directly to *you*.

Pre-admission Testing
Benefits will be provided for the *outpatient facility* charge and associated professional fees for diagnostic services rendered within 72 hours of a scheduled procedure performed at an *inpatient* or *outpatient facility*.

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*.

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*. *We* 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*.

Major Medical Expense Benefits

Ambulance Service Benefits
Prior authorization is not required for *emergency* ambulance transportation.

Note: non-emergency ambulance transportation requires *prior authorization*.

Covered service expenses will include ambulance services for local transportation:
1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury* in cases of *emergency*.
2. To the nearest available *hospital* or neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.
3. For the *temporarily medically disabled mother* of an ill *newly born* infant when accompanying the ill *newly born* infant to the nearest *hospital* or neonatal special care unit, upon recommendation by the mother's attending *physician* of her need for professional ambulance service.
4. Transportation between *hospitals* or between a *hospital* and a skilled nursing or *rehabilitation facility* when *authorized* by *us*.

Exclusions:
No benefits will be paid for:
5. Expenses incurred for *ambulance services* covered by a local governmental or municipal body, unless otherwise required by law.
6. Non-*emergency* air ambulance.
7. *Ambulance services* provided for a *member's* comfort or convenience.
8. Non-*emergency* transportation excluding ambulances (for example, transport-van, taxi).

Air Ambulance Service Benefits
Covered service expenses will include *ambulance services* for ground, water, fixed wing and rotary wing air transportation from home, scene of accident, or medical emergency:
5. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury* in cases of *emergency*.
6. To the nearest available *hospital* or neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.
7. For the *temporarily medically disabled mother* of an ill *newly born* infant when accompanying the ill *newly born* infant to the nearest *hospital* or neonatal special care unit, upon recommendation by the mother's attending *physician* of her need for professional ambulance service.
8. Transportation between *hospitals* or between a *hospital* and a skilled nursing or *rehabilitation facility* when *authorized* by *us*.

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.

Benefits for air *ambulance services* are limited to:
3. Services requested by police or medical authorities at the site of an *emergency*.
4. Those situations in which the *member* is in a location that cannot be reached by ground ambulance.

Exclusions:
No benefits will be paid for:

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

Ambulatory Patient Services
Covered Service and supply expenses for ambulatory patient services will include Medically Necessary services delivered in settings other than a *Hospital* or *Rehabilitation* or *Extended Care Facility*, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat *illness* or *injury*. Such services include in-*network*:

8. *Hospice* and Home Healthcare, including skilled nursing care as an alternative to hospitalization;
9. Provider office visits and treatments, and associated supplies and services, including therapeutic injections and related supplies;
10. *Urgent Care Center* visits, including Provider services, Facility costs and supplies;
11. Ambulatory *Surgery* Center (see below provision);
12. Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures;
13. Oral *Surgery* related to trauma and *injury*, including services or appliances necessary for or resulting from medical treatment if the service is either emergency in nature or requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease; and
14. *Physician* contraceptive services and supplies including, but not limited to, vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.

Ambulatory Surgical Center
Outpatient Services and supplies provided at an in-*network* Ambulatory *Surgery* Center including:

8. Anesthesiology;
9. Surgical Services;
10. Laboratory Services;
11. Recovery Care;
12. Patient Care Services;
13. Surgical supplies; and
14. Facility costs (including services of staff Providers billed by the *Hospital*).

Attention Deficit/Hyperactivity Disorder
The diagnosis and treatment for Attention Deficit/Hyperactivity Disorder is *covered* when rendered or prescribed by a *physician*. *You* must pay the *copayment*, *deductible*, and *coinsurance* that apply to the type of provider rendering services for this condition.

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

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

- evaluation and assessment services;
- *applied behavior analysis therapy*;
- behavior training and behavior management;
- *habilitation services* for individuals with a diagnosis of *autism spectrum disorder*;
- 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*.

Members who have not yet reached their twenty-first (21st) birthday are eligible for *applied behavior analysis* services. *Applied behavior analysis* is not covered for *members* age twenty-one (21) and older. 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*.

Chiropractic Services

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

Cleft Lip and Cleft Palate Services

The following services for treatment and correction of *cleft lip and cleft palate* are *covered*:

- oral and facial *surgery*, surgical management, and follow-up care;
- prosthetic treatment, such as obturators, speech appliances, and feeding appliances;
- orthodontic treatment and management;
- preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy;
- speech/language evaluation and therapy;
- audiological assessments and amplification devices;
- otolaryngology treatment and management;
- psychological assessment and counseling; and
- genetic assessment and counseling for patient and parents.

Coverage is also provided for secondary conditions and treatment attributable to the primary medical condition.

Contraception

All FDA-approved contraception methods (identified on www.fda.gov) are approved for *members* without *cost sharing* as required under the Affordable Care Act. *Members* have access to the methods available and outlined on *our* Drug Formulary or Preferred Drug List without *cost share*. Some contraception methods are available through a *member's* medical benefit, including the insertion and removal of the contraceptive device at no *cost share* to the *member*. This benefit contains both pharmaceutical and medical methods, including:

19. Sterilization *surgery* for women;
20. Surgical sterilization via implant for women;
21. Implantable rods;
22. Copper intrauterine devices;
23. Intrauterine devices with progestin;

24. The shot or injection;
25. Oral contraceptives (combined pill);
26. Oral contraceptives (progestin only);
27. Oral contraceptives (extended or continuous use);
28. The contraceptive patch;
29. Vaginal contraceptive rings;
30. Diaphragms;
31. Contraceptive sponges;
32. Cervical caps;
33. Female condoms;
34. Spermicides;
35. Emergency contraception; and
36. Additional methods as identified by the FDA.

COVID-19 Services
Approved diagnostic tests, antibody tests, and antiviral drugs that are ordered by *your physician* for the purpose of making clinical decisions or treating *you* if *you* are suspected of having COVID-19 are covered under this *contract*.

The approved diagnostic tests and antibody tests do not include a test used for employment-related or public health surveillance testing and, regardless of medical necessity, any COVID-19 diagnostic tests or antibody tests for those purposes are excluded from coverage.

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

Benefits are available for *medically necessary* items of diabetic supplies and blood glucose monitors (including non-invasive monitors and monitors for the blind) for which a *medical practitioner* has written an order.

Members that have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes or non-insulin diabetes may need to be educated on their condition and trained to manage their condition. *Coverage* is available for self-management training and education, dietician visits and for the equipment and necessary supplies for the training, if prescribed by the *member's physician*.

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

Covered expenses include:
5. Services provided in an outpatient dialysis facility or when services are provided in the home;
6. Processing and administration of blood or blood components;
7. Dialysis services provided in a *hospital*; and
8. Dialysis treatment of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

After *you* receive appropriate training at a dialysis facility *we* designate, *we* cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis. Coverage is limited to the standard item of equipment or supplies that adequately meets *your* medical needs. *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.

Dietician Visits
Benefits are available for outpatient visits to registered dieticians. One (1) dietician visit is covered at no cost to *members* when performed by a *network provider*. All other subsequent dietician visits are covered according to the cost share as outlined in *your Schedule of Benefits*. Diabetics that need the services of a dietician should receive those services as part of their benefits for diabetic care.

Disposable Medical Equipment and Supplies
Disposable medical equipment and supplies, which have a primary medical purpose are covered and are subject to reasonable quantity limits as determined by *us*. The equipment and supplies are subject to the *member*'s medical *deductible* and *coinsurance*.

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

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

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

5. The equipment, supply, or appliance is worn out or no longer functions.
6. 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.
7. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
8. The equipment, supply, or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include the following:

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

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

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

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

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

9. Hemodialysis equipment.
10. Crutches and replacement of pads and tips.
11. Pressure machines.
12. Infusion pump for IV fluids and medicine.
13. Glucometer.
14. Tracheotomy tube.
15. Cardiac, neonatal, and sleep apnea monitors.
16. Augmentative communication devices are covered when *we approve* based on the *member's* condition.

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

9. Air conditioners.
10. Ice bags/coldpack pump.
11. Raised toilet seats.
12. Rental of equipment if the *member* is in a facility that is expected to provide such equipment.
13. Translift chairs.
14. Treadmill exerciser.
15. Tub chair used in shower.
16. 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.

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

<u>Medical and surgical supplies</u>
Coverage for non-durable medical supplies and equipment for management of disease and treatment of medical and surgical conditions.
Covered services and supplies may include, but are not limited to:

6. Allergy serum extracts.
7. Chem strips, Glucometer, Lancets.
8. Clinitest.
9. Needles/syringes.
10. 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:

8. Adhesive tape, band aids, cotton tipped applicators.
9. Arch supports.
10. Doughnut cushions.
11. Hot packs, ice bags.
12. Vitamins (except as provided for under Preventive benefits).
13. Medijectors.
14. Items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Orthotic devices

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

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

10. Cervical collars.
11. Ankle foot orthosis.
12. Corsets (back and special surgical).
13. Splints (extremity).
14. Trusses and supports.
15. Slings.
16. Wristlets.
17. Built-up shoe.
18. 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:

5. Orthopedic shoes (except therapeutic shoes for diabetics).
6. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
7. Standard elastic stockings, garter belts, and other supplies not specifically made and fitted (except as specified under Medical Supplies).
8. 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 if:

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

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

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

9. 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.
10. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
11. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per benefit period, as required by the Women's Health and Cancer Rights Act. Maximums for *prosthetic devices*, if any, do not apply.

12. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
13. 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.
14. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
15. Restoration prosthesis (composite facial prosthesis).
16. Wigs (the first one following cancer treatment, not to exceed one per benefit period), when purchased through a *participating provider*.

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

6. Dentures, replacing teeth, or structures directly supporting teeth.
7. Dental appliances.
8. Such non-rigid appliances as elastic stockings, garter belts, arch supports, and corsets.
9. Wigs (except as described above following cancer treatment).
10. Penile prosthesis in adults suffering impotency resulting from disease or *injury*.

Rehabilitation, and Extended Care Facility Expense Benefits
Covered service expenses include services provided or expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:

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

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

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

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

Habilitation Expense Benefits
Inpatient and outpatient *habilitation services* are a covered benefit. *Covered service expenses* include: physical, occupational and speech therapies, developmental services, *durable medical equipment* for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder.

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

Hearing Benefits

3. Benefits are available for hearing aids for *members* age 17 and under when obtained from a *network provider*. This benefit is limited to 1 hearing aid for each ear with hearing loss every 36 months. The hearing aid must be fitted and dispensed by a licensed audiologist, licensed hearing aid specialist or a hearing aid dealer after the medical clearance of a *physician* and an audiological evaluation medically appropriate to the age of the child. Note: A parent or guardian may choose a hearing aid for the child that is priced higher than the benefit payable (based on the *network provider's* contracted amount) and pay the difference between the price of the hearing aid and the benefit payable, without financial or contractual penalty to the provider of the hearing aid.
4. Implantable bone conduction hearing aids, cochlear implants and bone-anchored hearing aids (BAHA) are covered for all *members*, regardless of age, the same as any other service or supply, subject to *medical necessity* and payment of applicable *copayments*, *deductibles*, and *coinsurance*.

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

9. *Home health aide services*.
10. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to *your Schedule of Benefits* for any limits associated with this *benefit*.
11. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
12. I.V. medication and pain medication.
13. Hemodialysis, and for the processing and administration of blood or blood components.
14. *Necessary medical supplies*.
15. Rental of *medically necessary durable medical equipment*.
16. Sleep studies.

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

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

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

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

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

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

Benefits for *hospice inpatient*, home and outpatient care are available for 5 days per episode.

Exclusions and Limitations:
Any exclusion or limitation contained in the *policy* regarding:

4. An *injury* or *illness* arising out of, or in the course of, employment for wage or profit;
5. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice* care program; or
6. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision.

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

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

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

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

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

28. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies.
29. Made by a *physician* for professional services, including *surgery.*
30. Made by an assistant surgeon.

31. For the professional services of a *medical practitioner*, including *surgery*.
32. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
33. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).
34. For chemotherapy and radiation therapy or treatment.
35. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
36. For the cost and administration of an anesthetic.
37. For oxygen and its administration.
38. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See the *Schedule of Benefits* for benefit levels or additional limits.
39. For accidental *dental services* when a *covered person* suffers an *injury,* after the *covered person's effective date* of coverage, that results in:
    a. Damage to the *member's* natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
40. For reconstructive breast procedures and *surgery* charges as a result of a partial mastectomy or a full unilateral or bilateral mastectomy. Such services shall be the choice of the *member* in consultation with the *member*'s *physician* and shall not be denied. Coverage includes *surgery* and reconstruction of the other breast to produce a symmetrical appearance, including but limited to contralateral prophylactic mastectomy, liposuction performed for transfer to a reconstructed breast or to repair a donor site deformity, tattooing the areola of the breast, surgical adjustments of the non-mastectomized breast, unforeseen medical complications which may require additional reconstruction in the future; prostheses; and treatment of physical complications of all stages of the mastectomy, including lymphedemas. These *covered services* shall be delivered in a manner determined in consultation with the attending *physician* and the *member*.
41. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the *Schedule of Benefits* for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *policy,* including the *deductible amount* and *percentage* provisions.
42. 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.
43. 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.
44. *Medically necessary services* made by a *provider* who renders services in an in-*network urgent care center*, including facility costs and supplies.
45. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
46. Allergy testing.
47. *Medically necessary telemedicine services* subject to the same clinical and *utilization review* criteria, plan requirements, limitations and *cost sharing* as the same health care services when delivered to an insured in person.
48. For *medically necessary* genetic or molecular cancer testing, including but not limited to, tumor mutation testing, next generation sequencing, hereditary germline mutation testing, pharmacogenomics testing, whole exome, genome sequencing and biomarker testing.
49. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
50. For *medically necessary* biofeedback services.
51. For *medically necessary* allergy treatment.

52. Therapeutic abortion performed to save the life or health of the *member*, or as a result of incest or rape.
53. Cochlear implants and bone anchored hearing aids.
54. Second surgical opinions are *covered* subject to any *copayments, deductible* and *coinsurance*, but are not mandatory to receive benefits.

Interpreter Expenses for the Deaf or Hard of Hearing
Services performed by a qualified interpreter or transliterator are covered when *you* need such services in connection with medical treatment or diagnostic consultations performed by a *provider*, if the services are required because of hearing loss or *your* failure to understand or otherwise communicate in spoken language. Services rendered by a family member are not covered.

Low-Protein Food Products for Treating Inherited Metabolic Diseases
Low-protein food products for treating certain inherited metabolic disease are covered. Inherited metabolic diseases are diseases caused by an inherited abnormality of body chemistry. Low-protein food products are foods that are especially formulated to have less than 1 gram of protein per serving and are intended to be used under the direction of a *physician* for the dietary treatment of an inherited metabolic disease. Low protein food products do not include natural foods that are naturally low in protein.

Benefits for low-protein food products are limited to treating the following diseases:
- Phenylketonuria (PKU)
- Maple Syrup Urine Disease (MSUD)
- Methylmalonic Acidemia (MMA)
- Isovaleric Acidemia (IVA)
- Propionic Acidemia
- Glutaric Acidemia
- Urea Cycle Defects
- Tyrosinemia

Lymphedema Benefit
Treatment of lymphedema is covered when rendered or prescribed by a licensed *physician* or received in a *hospital* or other public or private facility *authorized* to provide lymphedema treatment. Coverage includes multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

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

Our behavioral health and substance use vendor oversees the delivery and oversight of covered *behavioral health* and *substance use disorder* services for Ambetter. If *you* need mental health or *substance use disorder* treatment, *you* may choose any *provider* participating in *our behavioral health* and substance use vendor's *provider network* and do not need a referral from *your PCP* in order to initiate treatment. *You* can search for in-*network Behavioral Health providers* by using *our* Find a Provider tool at https://www.louisianahealthconnect.com/ or by calling *Member* Services at 1-866-595-8133 (TTY/TDD 711). *Deductible amounts, copayment*, or *coinsurance* amounts and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

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

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

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

Inpatient

8. *Inpatient* detoxification treatment;
9. Observation;
10. Crisis Stabilization;
11. *Inpatient rehabilitation*;
12. *Residential treatment facility* for mental health and *substance abuse*;
13. *Inpatient* Psychiatric Hospitalization; and
14. Electroconvulsive Therapy (ECT).

Outpatient

16. Individual and group mental health evaluation and treatment;
17. *Outpatient services* for the purpose of monitoring drug therapy;
18. Medication management services;
19. Outpatient detoxification programs;
20. Psychological and Neuropsychological testing and assessment;
21. Outpatient *rehabilitation* treatment;
22. *Applied behavioral analysis*;
23. Telemedicine;
24. Partial Hospitalization Program (PHP);
25. Intensive Outpatient Program (IOP);
26. Mental health day treatment;
27. Electroconvulsive Therapy (ECT);
28. *Transcranial magnetic stimulation (TMS)*;
29. *Assertive community treatment (ACT);*
30. The diagnosis and treatment for attention deficit/hyperactivity disorder when rendered or prescribed by a licensed *physician* or other *health care provider* licensed in this state and received in an appropriate setting.

In addition, Integrated Care Management is available for all of *your* health care needs including *behavioral health* and substance use. Please call 1-866-595-8133 (TTY/TDD 711) to be referred to a care manager for an assessment.

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

Other Dental Services

Anesthesia and *hospital* charges for dental care, for a *member* less than 19 years of age or a *member* who is physically or mentally disabled, are covered if the *member* requires dental treatment to be given in a *hospital* setting and for associated *hospital* charges when the *member's* mental or physical condition requires dental treatment to be rendered in a *hospital* setting . This coverage does not apply to treatment for temporomandibular joint disorders (TMJ).

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

8. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including *medically necessary* repairs or replacement to restore or maintain a *member's* ability to perform activities of daily living or essential job-related activities.
9. For one pair of foot orthotics per year per *covered person*.
10. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
11. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
12. For the rental of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint *surgery*.
13. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns.
14. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract *surgery*.

Pediatric Vision Expense Benefits – Children under the age of 19
Coverage for vision services is provided for children, under the age of 19, from a *network provider* through the end of the plan year in which they turn 19 years of age. This plan is compliant with the FEDVIP 2014 Vision Benefit Plan.

6. Routine ophthalmological exam
    a. Refraction;
    b. Dilation;
    c. Contact lens fitting.
7. Frames
8. Prescription lenses
    a. Single;
    b. Bifocal;
    c. Trifocal;
    d. Lenticular;
    e. Contact lenses (in lieu of glasses)
9. 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.
10. Low vision aids as *medically necessary*. Subject to *prior authorization*, *members* with low vision will receive the following:
    a. One comprehensive evaluation every 5 years. This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast and lighting requirements for optimum vision.

b. 1 device per year such as high-power spectacles, magnifiers and telescopes. These devices maximum use of available vision, reduce problems of glare or increase contrast perception, based on the person's visual goals and lifestyle needs.
c. 4 follow-up visits in any 5-year period.

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 https://www.louisianahealthconnect.com/ or call *Member* Services.

Covered service expenses do not include:
4. Visual therapy;
5. Two pair of glasses as a substitute for bifocals;
6. Non-*network* care without *prior authorization*;

Vision Expense Benefits Routine Vision Adult aged 19 years of age and over
Coverage for vision services is provided for adults, age 19 and older, from a *provider*.
4. Routine ophthalmological exam
    a. Refraction;
    b. Dilation;
    c. Contact lens fitting.
5. Frames
6. 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 https://www.louisianahealthconnect.com/ or call *Member* Services.
Services not covered:
3. Visual therapy; and
4. Low vision services and hardware for adults.

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.*
4. Preventive and Diagnostic (Routine *Dental Services*) – Class 1 benefits include:
    e. Routine Cleanings;
    f. Oral Exams;
    g. X-rays – bite-wing, full-mouth and panoramic film; and
    h. Topical fluoride application.
5. 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; and
    e. Prosthodontics –relines, rebase, adjustment and repairs.
6. 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 https://www.louisianahealthconnect.com/ or call *Member* Services.

Services not covered include:

31. *Dental services* that are not necessary or specifically covered;
32. Hospitalization or other facility charges;
33. *Prescription drugs* dispensed in the dental office;
34. Any dental procedure performed solely as a cosmetic procedure;
35. Charges for dental procedures completed prior to the *member*'s *effective date* of coverage;
36. Services provided by an anesthesiologist;
37. 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;
38. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles;
39. Any artificial material implanted or grafted into soft tissue or bone, surgical removal of implants, and implant services;
40. Sinus augmentation;
41. Surgical appliance removal;
42. Intraoral placement of a fixation device;
43. Oral hygiene instruction, tobacco counseling, nutritional counseling or high-risk substance abuse counseling;
44. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture;
45. Any oral *surgery* that includes surgical endodontics (apicoectomy and retrograde filling);
46. Analgesia (nitrous oxide);
47. Removable unilateral dentures;
48. Temporary procedures;
49. Splinting;
50. Temporal Mandibular Joint disorder (TMJ) appliances, therapy, films and arthorograms;
51. Oral pathology laboratory charges;
52. Consultations by the treating *provider* and office visits;
53. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
54. Veneers (bonding of coverings to the teeth);
55. Orthodontic treatment procedures;
56. Orthognathic *surgery*;
57. Athletic mouth guards;
58. Space maintainers;
59. Dental procedures or restoration to alter or increase vertical dimension of occlusion; and
60. Dental procedures or restorations to restore or repair loss of tooth structure caused by abrasion, abfraction, or erosion.

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:

5. A *prescription drug.*
6. Prescribed, self-administered anti-cancer medication.

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

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

Formulary or Prescription Drug List
This plan uses one *formulary* for all products covered under this *policy*. No product offered under this *policy* is issued without a *formulary*.

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. The *formulary* lists drugs on different tiers which represent varying cost share amounts. In general, drugs listed on lower *formulary* tier will be associated with lower *member* cost share amount. Most generic medications are listed on the lowest formulary cost share tier. 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 higher on the Drug List tier than generic drugs 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 that not all dosage forms or strengths of a drug may be covered. If a drug is not listed on the formulary it means that the drug is not covered and it is considered non-formulary. *You* have the right to request a non-formulary exception request review from *us*. Please review the Prescription Drug Exception Process section below for additional information.

This list is reviewed and updated at least quarterly. Positive changes, such as removal of utilization management restrictions and addition of drugs to the formulary can take place monthly. Negative changes, such as addition of *Prior Authorization* requirement will take place only at the beginning of each new benefit year. The formulary is reviewed by *our* Pharmacy and Therapeutics Committee (P&T). The P&T, consisting of practicing *physicians*, pharmacists and dentist, evaluates clinical aspects of each drug. Strategy Development Committee, a subcommittee of the P&T consisting of data analysts and pharmacists, determines the financial aspects of each drug. Together those two committees determine drug placement and any utilization management restrictions. If two drugs are clinically expected to produce same outcomes then the placement of the drug is based on financial aspects.

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the formulary. For the most current Ambetter Formulary or Prescription Drug List or for more information about *our* pharmacy program, visit https://www.louisianahealthconnect.com/ (under “For Member”, “Pharmacy Resources”) or call *Member* Services at 1-866-595-8133 (TTY/TDD 711).

Step Therapy
Step therapy means a utilization management policy for coverage of drugs that begins medication for a medical condition with the most preferred or cost effective drug therapy and progresses to other drug therapies if medically necessary. Step therapy is part of *our* formulary design and design of this plan.

Notice of Disclosure of Prescription Drug Formulary:
We offer several convenient ways to obtain and review current formulary and inquire if a drug is covered on the *formulary*. For the most current Ambetter Formulary or Prescription Drug List or for more information about *our* pharmacy program, visit https://www.louisianahealthconnect.com/ (under "For Member", "Pharmacy Resources") or call *Member* Services at 1-866-595-8133 (TTY/TDD 711). If a *Prescription Drug* is on *your Prescription Drug* Formulary, this does not guarantee that *your* prescribing healthcare provider will prescribe it for a particular medical condition or mental *illness*. *We* will disclose to *you* upon request, not later than the third business day after the date of the request, whether a specific drug is included in *our* drug formulary.

Notice on excess cost:
We use any savings or rebates to stabilize rates. Any savings or rebates *we* receive on the cost of drugs purchased under this *policy* from drug manufacturers are used to stabilize rates. *You* may be subject to an excess consumer cost burden when *covered prescription drugs* are purchased under this *policy*.

Notification to providers:
If a prescribed drug is denied based upon the drug's nonformulary status, *we* will provide the prescriber with a list of alternative comparable formulary medications in writing and attached to the letter of denial or electronically for requests made by providers utilizing electronic health records with capabilities. If a prescribed drug is excluded from coverage under the health benefit plan and other drugs in the same class and used for the same treatment as the excluded drug are covered under the plan, *we* will notify the prescriber of the covered drug in writing and attached to the letter of denial or electronically for requests made by providers utilizing electronic health records with capabilities.

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 https://www.louisianahealthconnect.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 https://www.louisianahealthconnect.com/. *You* can also request to have a copy mailed directly to *you*.

Mail Order Pharmacy
If *you* have more than one prescription *you* take regularly, *you* may select to enroll in *our* mail order delivery program. *Your* prescriptions will be safely delivered right to *your* door at no extra charge to *you*. *You* will still be responsible for *your* regular *copayment*/*coinsurance*. To enroll for mail order delivery or for any additional questions, call *our* mail order pharmacy at 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.

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

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 medications(s) only at specified location. *Ambetter* pharmacy, together with Medical Management will review *member* profiles and using specific criteria, will recommend *members* for participation in the Lock-In Program. *Members* identified for participation in the Lock-In Program and associated *providers* will be notified of *member* participation in the program via mail. Such communication will include information on duration of participation, pharmacy to which *member* is locked-in, and any *appeals* rights.

Medication Balance-On-Hand
Medication refills are prohibited until *your* 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
You are limited to 15-day supplies for the first 90 days when starting new therapy using certain medications (like oral oncology). *You* 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, *you* will fill *your* medications for 30-day supplies.

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

Exception to step therapy or fail first protocol:
We will grant exception to step therapy or fail first protocol when:

1. The prescribing *physician* can demonstrate to the health coverage plan, based on sound clinical evidence, that the preferred treatment required under step therapy or fail first protocol has been ineffective in the treatment of the insured's disease or medical condition.
2. The prescribing *physician* can demonstrate to the health coverage plan, based on sound clinical evidence, that the preferred treatment required under the step therapy or fail first protocol is reasonably expected to be ineffective based on the known relevant physical or mental characteristics and medical history of the insured and known characteristics of the drug regimen.
3. The prescribing *physician* can demonstrate to the health coverage plan, based on sound clinical evidence, that the preferred treatment required under the step therapy or fail first protocol will cause or will likely cause an adverse reaction or other physical harm to the insured.
4. For product approved under this section *we* will issue an approval letter outlining coverage under this *policy*. For any product denied under this section *you* have the right to *appeal our* decision. Any product requested under this section will be reviewed within 72 hours of receipt of the request for standard requests and within 24 hours of receipt of urgent or exigent request.

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

Should the standard exception request or step therapy protocol exception request be granted, *we* will provide coverage of the non-formulary drug for the duration of the prescription, including refills, or of the drug that is the subject of the protocol exception.

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

If *we* do not respond to exception requests as outlined above, such exception should be deemed approved.

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. The independent review organization will make a determination on the external exception request and notify the *member*, the *member's* designee or the *member's* prescribing *physician* of the coverage determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception.

We will cover any medication approved under the exception requests described above for the duration stated on the original request or 12 months, whichever is shorter. Subsequent coverage may necessitate further reviews.

We do not apply fail first or step therapy protocols for drugs used in treatment of stage-four advanced metastatic cancer or associated conditions. This is reflected in *our prior authorization* criteria.

Notification of change in prescription drug or intravenous infusion coverage
If *we* change *our* coverage of a particular *prescription drug* or intravenous infusion based on medical necessity and *you* were utilizing this product in the past for at least 60 days, *we* will provide *you* with at least 60 days advanced notice of proposed change. *You* have the right to *appeal* this proposed change. To start the *appeal* process please reach out to *your* provider. *Your* provider can utilize regular *appeals* process for purposes of this section.

Change in formulary coverage
We will remove drugs from the formulary or otherwise restrict drugs with utilization management techniques only once a year at the time of the renewal.

Oral cancer drugs
We will provide oral cancer drugs at no less favorable terms than intravenously administer or injected cancer medications. This provision does not apply if *you* are on a High *Deductible* Health Plan or policies used together with a health savings account, medical savings account or similar program.

Cost share contribution
Any *copay* or *cost share* amount paid by *you* or on *your* behalf by a *third party* will be counted in *your* annual accumulators.

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

25. For *prescription drug* treatment of erectile dysfunction or any enhancement of sexual performance unless such treatment is listed on the formulary.
26. For weight loss *prescription drugs* unless otherwise listed on the formulary.
27. For immunization agents, blood, or blood plasma, except when used for preventive care and listed on the formulary.
28. For medication that is to be taken by the *member,* in whole or in part, at the place where it is dispensed.
29. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
30. For a refill dispensed more than 12 months from the date of a *physician's* order.
31. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
32. 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. This exclusion does not apply to prescribed FDA approved contraceptive methods.
33. For drugs labeled "Caution - limited by federal law to investigational use" or for *investigational* or *experimental* drugs.
34. For any drug that *we* identify as therapeutic duplication through the Drug Utilization Review program.
35. For more than a 30-day supply when dispensed in any one prescription or refill, or for some maintenance drugs, up to 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply *network*. Specialty drugs and other select drug categories are limited to 30-day supply when dispensed by retail or mail order. Please note that only the 90-day supply is subject to the discounted *cost sharing*. Mail orders less than 90 days are subject to the standard *cost sharing* amount.
36. 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.
37. Foreign Prescription Medications, except those associated with an *emergency medical condition* while *you* are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this document if obtained in the United States.
38. 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.
39. For medications used for cosmetic purposes.
40. For infertility drugs unless otherwise listed on the formulary.
41. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
42. 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.
43. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
44. For any drug dispensed from a non-lock-in pharmacy while *member* is in a lock-in program.
45. For any drug related to *surrogate pregnancy*.
46. For any drug used to treat hyperhidrosis.
47. 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.
48. Medication refills where a *member* has more than 15 days' supply of medication on hand.

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:

6. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. Examples of these services are screenings for breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, prostate specific antigen testing, and screenings for child and adult obesity.
7. 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.
8. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.
9. 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 including screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum.
10. Covers without *cost sharing*:
    a. Routine wellness physical exam – certain routine wellness diagnostic tests ordered by *your physician* are covered. Examples of routine wellness diagnostic tests include tests such as a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol and blood sugar levels.
    b. Well baby care – routine examinations will be covered for infants younger than 24 months old for whom no diagnosis is made.
    c. Routine annual visits to an obstetrician or gynecologist. Additional visits that *your* obstetrician or gynecologist recommends may be subject to a *deductible amount*, *copayment* or *coinsurance* percentage shown on the *schedule of benefits*, unless they are preventive services.
    d. One routine pap smear per *benefit period*.
    e. All film mammograms, 3-D mammograms (digital breast tomosynthesis), and breast ultrasounds are covered at no cost to *you* when obtained from a *network provider*. Note: mammograms considered diagnostic may be subject to *cost sharing*.
    f. Bone Mass Measurement – scientifically proven tests for diagnosing and treating osteoporosis if a *Member* is:
        i. An estrogen deficient woman at clinical risk of osteoporosis who is considering treatment;
        ii. An individual receiving long-term steroid therapy; or
        iii. An individual being monitored to assess the response to or efficiency of approved osteoporosis drug therapies.
    g. BRCA1 & BRCA2 Genetic Testing – genetic testing of BRCA1 and BRCA2 genes will be covered at no cost to *you* to detect an increased risk of breast and ovarian cancer when recommended by a healthcare provider in accordance with the United States Preventive Services Task Force.
    h. Screening for nicotine or tobacco use; and
    i. 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 health care *provider* without *prior authorization*.

Benefits for preventive health services listed in this provision, are exempt from any *deductible amounts, cost sharing percentage* provisions, and *copayment amounts* under the *policy* when the services are provided by a *network provider.* If a service is considered diagnostic or non-preventive, *your* plan *copayment*, *coinsurance*, and *deductible* will apply. It's important to know what type of service *you 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.

Clinical Trial Coverage

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

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

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

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

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

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

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

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

Colorectal Cancer Examinations and Laboratory Tests
Covered service expenses include "colorectal cancer tests" for any non-symptomatic *covered person*, in accordance with the recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.

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*.

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.

Mammography
We include benefits payable for minimum mammography examination, including but not limited to digital breast tomosynthesis (DBT). Minimum mammography examination means mammography examinations performed no less frequently than the following schedule provides:

- One baseline mammogram for any woman who is 35 through 39 years of age.
- Annual mammogram (DBT preferred modality) for any woman who is 40 or older.
- Consideration is given to women with a hereditary susceptibility from pathogenic mutation carrier status or prior chest wall radiation, an annual MRI starting at age 25 and annual mammography (DBT preferred modality) starting at age 30.

Such examinations shall be in accordance with recommendations by National Comprehensive Cancer *Network* guidelines or the American Society of Breast Surgeons Position Statement on Screening Mammography no later than the following *policy* or plan year following changes in the recommendations. Annual mammography (DBT preferred modality) and access to supplemental imaging (MRI preferred modality) starting at age thirty-five upon recommendation by her *physician* if the woman has a predicted lifetime risk greater than twenty percent by any validated model published in peer reviewed medical literature.

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 artificial insemination (AI) in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT).

Maternity Care
Coverage for outpatient and *inpatient* pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and *hospital* stays for delivery or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or *cost sharing percentage*). An *inpatient* stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. *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 to *us*. Other maternity benefits include *complications of pregnancy,* parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests. Coverage will only be provided for maternity services or care of the newborn child when such services have been *authorized* by *your* participating health care *provider*.

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 health care *provider* obtain *authorization* for prescribing a length of stay of up to 48 hours (or 96 hours).

Note: This provision does not amend the *policy* to restrict any terms, limits, or conditions that may otherwise apply to *covered service expenses* for maternity care.

3. Give birth in a *hospital* or other healthcare facility
4. Remain under *inpatient* care in a *hospital* or other healthcare facility for any fixed term following the birth of a child

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

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

Duty to Cooperate
We do not cover services or supplies related to a *member*'s *pregnancy* when a *member* is acting as a *surrogate* and has entered into a *surrogacy arrangement*. For more information on excluded services, please see the General Non Covered Services and Exclusions section. *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 Ambetter of Louisiana Healthcare Connections, *Member* Services, 8585 Archives Avenue, Suite 310, Baton Rouge, LA 70809. In the event that a *member* fails to comply with this provision, *we* reserve *our* right to enforce this *policy* on the bases of fraud, misrepresentation or false information, up to and including recoupment of all benefits that *we* paid on behalf of the *surrogate* during the time that the *surrogate* was insured under *our policy*, plus interest, attorneys' fees, costs and all other remedies available to *us*.

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.

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

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

Metastatic or Unresectable Tumors
We cover metastatic or unresectable tumors with a *medically necessary* drug prescribed by a *physician* on the sole basis that the drug is not indicated for the location in the body of the patient's cancer if the drug is approved by the United States Food and Drug Administration for the treatment of the specific mutation of the patient's cancer. *Coverage* is included for an initial treatment period of three (3) months. *Coverage* shall continue after the initial treatment period, if the treating *physician* certifies that the drug is *medically necessary* based on documented improvement of the patient.

Prostate Specific Antigen Testing
Covered service expenses include one (1) digital rectal exam and prostate-specific antigen (PSA) test per benefit period, is covered for *members* 50 years of age or older, and as recommended by his *physician* if the *member* is over 40 years of age. *Your* individual *deductible* does not apply.

A second visit will be permitted if recommended by *your physician* for follow-up treatment within 60 days and after either visit if related to a condition diagnosed or treated during the visits.

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).

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

4. Whenever a minor *surgical procedure* is recommended to confirm the need for the procedure;
5. Whenever a serious *injury* or *illness* exists; or
6. 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 *copayment* for the consultation. Any lab tests and/or diagnostic and therapeutic services are subject to the additional *copayment*.

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 *enrollees* to remove barriers to accessing health services and improve overall health outcomes. These are benefits and services that *we* may make available in connection with this contract. The benefits and services provided may include transportation to health services, assistance with childcare, access to healthy meals, and other

relevant services based on need. The benefits are available as long as coverage remains active, unless changed by *us*. Upon termination of coverage, the benefits are no longer available. All *enrollees* are eligible for the benefits upon obtaining coverage. The services are optional, and the benefits are made available at no additional cost to the *enrollees*. The benefits and services available at any given time are made part of this contract by this reference and are subject to change by *us* through an update to information available on *our* website or by contacting *us*.

Social determinants of health benefits and services may be offered to *enrollees* through the "My Health Pays" wellness program and through local health plan websites. *Enrollees* may receive notifications about available benefits and services through emails from local health plans and through the "My Health Pays" notification system. To inquire about these benefits and services or other benefits available, *you* may visit *our* website at https://www.louisianahealthconnect.com/ or by contacting *Member* Services at 1-866-595-8133 (TTY/TDD 711).

Transplant Expense Benefits
Covered Services For Transplant Service Expenses:

Transplants are a covered benefit when a *member* is accepted as a transplant candidate and pre-*authorized* in accordance with this *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:

7. If both the donor and recipient have coverage provided by the same insurer each will have their benefits paid by their own coverage program.
8. If *you* are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this contract will be provided for both *you* and the donor. In this case, payments made for the donor will be charged against *enrollees*' benefits.
9. 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.
10. 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 an *enrollee and donor* are an appropriate candidate for a *medically necessary* transplant, live donation, *covered service expenses* will be provided for:

10. Pre-transplant evaluation.
11. Pre-transplant harvesting of the organ from the donor.
12. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
13. 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.
14. Pre-transplant stabilization, meaning an *inpatient* stay to *medically stabilization* to prepare for a later transplant, whether or not the transplant occurs.
15. 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.
16. Post-transplant follow-up visits and treatments.
17. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.

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

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

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

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

11. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.
12. For animal to human transplants.
13. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the *Center of Excellence*.
14. To keep a donor alive for the transplant operation, except when authorized through the *Center of Excellence*.
15. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
16. Related to transplants unauthorized though the *Center of Excellence* and is not included under this provision as a transplant.
17. 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.
18. The acquisition cost for the organ or bone marrow, when provided at an un*authorized* facility or not obtained through the *Center of Excellence*.

19. For any transplant services and/or travel related expenses for *enrollee* and donor, when preformed outside of the United States.
20. 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
Members will not be subject to 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 during the enrollment year, *We* must, to the extent possible, notify the prescribing *physician* and the patient, or the parent or legal guardian if the *member* is a child, or the *spouse*/caretaker of a *member* who is *authorized* to consent to the treatment of the *member* 60 days prior to renewal or enrollment. 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 *member* 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 *member* requests a refill of the immunosuppressant drug, *we* may provide the *member* with the written notification required above along with a 60-day supply of the immunosuppressant drug under the same terms as previously allowed.

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

Members are encouraged to contact their *primary care provider* for an appointment before seeking care

from another *provider*, but *network urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *primary care provider* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-866-595-8133 (TTY/TDD 711). The 24/7 Nurse Advice Line is available twenty-four (24) hours a day, seven (7) days a week. A registered nurse can help *you* decide the kind of care most appropriate for *your* specific need.

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

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

You may obtain information regarding the particular programs available at any given time by visiting *our* website at https://www.louisianahealthconnect.com/ or by contacting *Member* Services by telephone at 1-866-595-8133 (TTY/TDD 711). The benefits are available as long as coverage remains active, unless changed by *us* as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All *members* are automatically eligible for program benefits upon obtaining coverage. These 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 1-866-595-8133 (TTY/TDD 711).

General Non-Covered Services and Exclusions

No benefits will be provided or paid for:

6. Any service or supply that would be provided without cost to the *member* in the absence of insurance covering the charge.
7. 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.
8. Any services performed by a *member* of a *member's immediate family.*
9. Any services not identified and included as *covered service expenses* under the *policy*. *You* will be fully responsible for payment for any services that are not *covered service expenses.*
10. Any services where other coverage is primary to Ambetter must be first paid by the primary payor prior to consideration for coverage under Ambetter.

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

3. Administered or ordered by a *physician*; and
4. *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:

43. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*, except as expressly provided for under the Benefits after Coverage Terminates clause in this *policy's* Termination section.
44. For any portion of the charges that are in excess of the *eligible service expense.*
45. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*, bariatric *surgery* and weight loss programs, except as specifically covered in the Major Medical Expense Benefits section of the *policy*.
46. For the reversal of sterilization and the reversal of vasectomies.
47. For non-therapeutic abortion.
48. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Major Medical Expense Benefits provision.
49. For expenses for television, telephone, or expenses for other persons.
50. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
51. For telephone consultations or for failure to keep a scheduled appointment.
52. For stand-by availability of a *medical practitioner* when no treatment is rendered.
53. For *dental service* expenses*,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits.
54. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* or is performed to correct a birth defect in a child.
55. Mental health services are excluded for:
    a. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
    b. Pre-marital counseling;
    c. Court ordered care or testing or required as a condition of parole or probation. Benefits will be allowed for services that are *medically necessary* and would otherwise be covered under this *policy*;
    d. Testing of aptitude, ability, intelligence or interest; and
    e. Evaluation for the purpose of maintain employment.
56. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.

57. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Service Expense Benefits.
58. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
59. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *policy)*.
60. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*.
61. 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.
62. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *policy*.
63. For hearing aids, except as expressly provided in this *policy*.
64. 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. Costs of *investigational treatment(s)* and costs of associated protocol-related patient care shall be covered only if the following criteria are met:
    a. The treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer.
    b. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer.
    c. The treatment is being provided in accordance with a clinical trial approved by qualifying entities.

    A health insurance issuer is not required to provide coverage for:
        1. Non-healthcare services.
        2. Costs for managing research data.
        3. Investigational drugs, devices, items or services.
65. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of ninety (90) consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
66. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's* workers' compensation claim, this exclusion will still apply unless that denial is *appealed* to the proper governmental agency and the denial is upheld by that agency.
67. For or related to treatment of hyperhidrosis (excessive sweating).
68. For fetal reduction *surgery*.
69. Except as specifically identified as a *covered service expense* under the *policy*, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
70. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or Semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or

mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).

71. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
72. 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.
73. For the following miscellaneous items: Artificial Insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *rehabilitation* services for the enhancement of job, athletic, or recreational performance; routine or elective care outside the *service area*; treatment of spider veins; transportation expenses, unless specifically described in this *policy*.
74. Diagnostic testing, laboratory procedures screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
75. For court ordered testing or care unless *medically necessary*.
76. For a *member's illness* or *injury* which is caused by the acts or omissions of a *third party*, *we* have a right of recovery for any benefits paid in excess. *Our* right of subrogation is secondary to the right of the *member* to be fully compensated for his damages.
77. *Surrogacy arrangement*. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a *member*, and any child born as a result of a *surrogacy arrangement*. This exclusion applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the *surrogate* following childbirth);
    d. Mental Health Services related to the *surrogacy arrangement*;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
    h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement*;
    i. Any complications of the child or *surrogate* resulting from the *pregnancy*; or
    j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*.

    Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except where the child is the adoptive child of insureds possessing an active *policy* with *us* and/or the child possesses an active *policy* with *us* at the time of birth.
78. For any medicinal and recreational use of cannabis or marijuana.
79. Any non-*medically necessary* court ordered care for a medical/surgical or mental health/*substance use disorder* diagnosis, unless required by state law.
80. Expenses for services related to immunizations for travel and occupational purposes.
81. Expenses for services related to massage therapist.
82. Expenses for services related to naprapathic services; and
83. Expenses for services related to naturopathic services.
84. Expenses for services related to temporomandibular joint (TMJ).
85. For treating any *member* detailed in a correctional facility who has been adjudicated or convicted of the criminal offense causing the detention.

Termination

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

6. Nonpayment of premiums when due, subject to the Grace Period provision in this *policy*;
7. The date *we* receive a request from *you* to terminate this *policy,* or any later date stated in *your* request;
8. The date *we* decline to renew this *policy,* as stated in the Discontinuance provision;
9. The date of *your* death, if this *policy* is an Individual Plan; or
10. The date a *member's* eligibility for coverage under this *policy* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *policy.*

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

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

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

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

Benefits After Coverage Terminates
Benefits for *covered service expenses* incurred after a *member* ceases to be covered are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *policy* is terminated because of:

4. A request by *you*;
5. Fraud or material misrepresentation on *your* part; or
6. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss*. The *period of extended loss* must begin before coverage of the *member* ceases under this *policy*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *policy* is terminated because *we* refuse to renew all policies issued on this form, to residents of the state where *you* live, termination of this *policy* will not prejudice a claim for a *continuous loss* that begins before coverage of the *member* ceases under this *policy.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

3. The date the *continuous loss* ends; or
4. 12 months after the date renewal is declined.

Right of Reimbursement

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

Louisiana Healthcare Connections' rights of recovery apply to any recoveries made by or on behalf of the *member* from any sources, including but not limited to:

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

To the extent that benefits for *covered services* are provided or paid under this contract, *we* will be subrogated and will succeed to *your* right for the recovery of the amount paid under this contract against any person, organization or other carrier even where such carrier provides benefits directly to *you*. The acceptance of such benefits hereunder will constitute such subrogation. *Our* right to recover will be subordinate to *your* right to be "made whole." *We* will be responsible for *our* proportionate share of the reasonable attorney fees and costs actually incurred by *you* in pursuing recovery.

By accepting benefits under this plan, the *member* specifically acknowledges Louisiana Healthcare Connections' right of recovery. Louisiana Healthcare Connections may proceed against any party with or without the *member's* consent.

By accepting benefits under this plan, the *member* also specifically acknowledges *our* right of reimbursement. This right of reimbursement attaches when this plan has provided health care benefits for expenses incurred due to *third party* injuries and the *member* or the *member's* representative has recovered any amounts from any source. *Our* right to recover will be subordinate to *your* right to be "made whole." *We* will be responsible for *our* proportionate share of the reasonable attorney fees and costs actually paid by *you* in pursuing recovery. *Our* right of reimbursement is cumulative with and not exclusive of Louisiana Healthcare Connections' right of recovery and *we* may choose to exercise either or both rights of recovery.

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

12. To fully cooperate with *us* in order to obtain information about the *loss* and its cause.
13. To *immediately* inform *us* in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.
14. To include the amount of benefits paid by *us* on behalf of a *member* in any claim made against any *third party*.
15. To give Louisiana Healthcare Connections a first-priority lien on any recovery, settlement or judgment or other sources of compensation which may be had from any party to the extent of the full cost of all benefits associated with *third party* injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
16. To pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due Louisiana Healthcare Connections as reimbursement for the full cost of all benefits associated with *third party* injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement).

17. That *we*:
    a. Will have a lien on all money received by a *member* in connection with the *loss* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.
    d. Are entitled to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert the right of reimbursement independently of the *member*.
18. To take no action that prejudices *our* reimbursement rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan.
19. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement rights.
20. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
21. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
22. That *we* may reduce other benefits under the *policy* by the amounts a *member* has agreed to reimburse *us*.

If a dispute arises as to the amount a *member* must reimburse *us*, the *member* (or the guardian, legal representatives, estate, or heirs of the *member*) 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.

Coordination of Benefits

Applicability

4. This Coordination of Benefits ("COB") section applies to this Plan when a *member* has healthcare coverage under more than one Plan. "Plan" is defined below.
5. This section is intended to describe the Order of Benefit Determination Rules that govern the order in 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 in accordance with its policy 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% of the total Allowable Expense.

Definitions (Applicable only to this section of the *policy*)

5. "Allowable Expense" means any healthcare service or expense, including *deductibles*, *coinsurance* or *copayments*, that is covered in full or at least in part by any Plan covering the person.
    a. 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.
    b. An expense or a portion of an expense that is not covered by any of the Plans is not an Allowable Expense.
    c. The following are examples of expenses that are not Allowable Expenses.
        i. If a person is confined in a private *Hospital* room, the difference between the cost of a semi-private room in the *Hospital* and the private room is not an Allowable Expense, unless one of the Plans provides coverage for private *Hospital* room expenses.
        ii. If a person is covered by two or more Plans that compute their Benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the Provider in excess of the highest reimbursement amount for a specified Benefit is not an Allowable Expense.
        iii. If a person is covered by two or more Plans that provide Benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.
    d. The following are examples of expenses that are Allowable Expenses.
        i. If a person is covered by one Plan that calculates its Benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan that provides its Benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans.
        ii. The amount of any Benefit reduction by the Primary Plan because a *covered person* has 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.
6. "Closed Panel Plan" a Plan that provides health Benefits to *covered persons* primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that excludes Benefits for services provided by other Providers, except in cases of emergency or referral by a panel member.
7. "Coordination of Benefits or 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.
8. "Custodial Parent"
    a. the parent awarded custody of a child by a court decree; or

b. in the absence of a court decree, the parent with whom the child resides more than one half of the *calendar year* without regard to any temporary visitation.

11. "Order of Benefit Determination Rules" determine whether this Plan is a Primary Plan or Secondary Plan when the person has 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.
12. "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.
    a. Plan includes:
        i. Group and non-group Insurance Contracts;
        ii. Health Maintenance Organization (HMO);
        iii. group and non-group coverage through Closed Panel Plans;
        iv. Group-Type Contracts (whether insured or uninsured);
        v. the medical care components of long-term care Contracts, such as skilled nursing care;
        vi. the medical Benefits under group or individual automobile Contracts;
        vii. Medicare or other governmental Benefits, as permitted by law.
    b. Plan does not include:
        i. *hospital* indemnity coverage Benefits or other fixed indemnity coverage;
        ii. accident only coverage;
        iii. specified disease or specified accident coverage;
        iv. limited Benefit health coverage as defined by state law;
        v. school accident-type coverage except those enumerated in LSA-R.S. 22:1000 A.3C;
        vi. Benefits provided in long-term care insurance policies for non-medical services;
        vii. Medicare supplement policies;
        viii. a state plan under Medicaid; or
        ix. coverage under other federal government plans, unless permitted by law.

Each Contract for coverage under a or b, listed 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.

Order of Benefit Determination Rules

3. When a person is covered by two or more Plans, the rules for determining the order of Benefit payments are as follows:
    b. The Primary Plan pays or provides its Benefits according to its terms of coverage and without regard to the benefits of under any *other Plan*.
        i. Except as provided in Paragraph (2) below, a Plan that does not contain a Coordination of Benefits Provision that is consistent with this section is always primary unless the provisions of both Plans state that the complying Plan is primary.
        ii. 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 the supplementary coverage shall be excess to any other parts of the Plan provided by the Policyholder. 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*.

4. Each Plan determines its order of Benefits using the first of the following rules that apply:
   c. Non-Dependent or Dependent Rule. The Plan that covers the person other than as a Dependent, for example as an Employee, *Member*, policyholder, *Subscriber* or retiree is the Primary Plan and the Plan that covers the person as a Dependent is the Secondary Plan. However, if the person is a Medicare *Beneficiary* and, as a result of federal law, Medicare is secondary to the Plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (e.g. a retired Employee); then the order of Benefits between the two Plans is reversed so that the Plan covering the person as an Employee, *Member*, policyholder, *Subscriber* or retiree is the Secondary Plan and the *other Plan* is the Primary Plan.
   d. Dependent Child Covered Under More Than One Plan Rules. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of Benefits is determined as follows:
      i. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
         (a) The Plan of the parent whose Birthday falls earlier in the *calendar year* is the Primary Plan; or
         (b) If both parents have the same Birthday, the Plan that has covered the parent the longest is the Primary Plan.
      ii. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
         (1) If a court decree states that one of the parents is responsible for the Dependent 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;
         (2) If a court decree states that both parents are responsible for the Dependent child's healthcare expenses or healthcare coverage, the provisions of Subparagraph (1) above shall determine the order of Benefits;
         (3) 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 Dependent child, the provisions of Subparagraph (1) above shall determine the order of Benefits; or
         (4) If there is no court decree allocating responsibility for the Dependent child's healthcare expenses or healthcare coverage, the order of Benefits for the child are as follows:
            A. The Plan covering the Custodial Parent;
            B. The Plan covering the *Spouse* of the Custodial Parent;
            C. The Plan covering the non-Custodial Parent; and then
            D. The Plan covering the *Spouse* of the non-Custodial Parent.
      iii. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraphs (1) or (2) above shall determine the order of Benefits as if those individuals were the parents of the child.
      iv. For a Dependent child covered under the *Spouse's* Plan:
         (3) For a Dependent child who has coverage under either or both parents' Plans and also has his or her own coverage as a Dependent under a *Spouse's* Plan, the Longer or Shorter Length in Coverage Rule applies.
         (4) In the event the Dependent child's coverage under the *Spouse's* Plan began on the same date as the Dependent child's coverage under either or both parents' Plans, the order of Benefits shall be determined by applying the birthday rule above in Subparagraph (1) to the Dependent child's parent(s) and the Dependent's *Spouse*.

d. Active Employee or Retired or Laid-off Employee Rule. The Plan that covers a person as an active Employee, that is, an Employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off Employee is the Secondary Plan. The same would hold true if a person is a Dependent of an active Employee and that same person is 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 of Subparagraph (2) can determine the order of Benefits.
e. COBRA or State Continuation Coverage Rule. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an Employee, *Member*, *Subscriber* or retiree or covering the person as a Dependent of an Employee, *Member*, *Subscriber* or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the *other Plan* does not have this rule, and as a result, the Plans do not agree on the order of Benefits, this rule is ignored. This rule does not apply if the rule of Subparagraph (2) determine the order of Benefits.
f. Longer or Shorter Length of Coverage Rule. The Plan that covered the person as an Employee, *Member*, policyholder, *Subscriber* or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
g. Fall-Back Rule. If none of the preceding rules determine the order of Benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In any event, this Plan will never pay more than it would have paid had it been the Primary Plan.

Effects on the Benefits of this Plan

1. When this Plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all Plans during a Plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any Claim, the Secondary Plan will 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 shall credit to its Plan *Deductible*, *Coinsurance*, *Copayments* and any amounts it would have credited to its *Deductible* in the absence of other healthcare coverage. In any event, This Plan will never pay more than it would have paid had it been the Primary Plan.
5. The difference between the Benefit payments that this Plan would have paid had it been the Primary Plan, and the Benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the *covered person* and used by this Plan to pay any Allowable Expenses, not otherwise paid during the Claim determination period. As each Claim is submitted, this Plan will:
    a. Determine its obligation to pay or provide benefits under its contract;
        i. Determine whether a benefit reserve has been recorded for the *covered person*; and
        ii. Determine whether there are any unpaid Allowable Expenses during that claim determination period.
6. If there is a benefit reserve, the Secondary Plan will use the *covered person's* benefit reserve to pay up to 100 percent of total Allowable Expenses incurred during the Claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new Claim determination period.
7. If a *covered person* is 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 Plans.

You may request a copy in either paper form or electronic form of Appendix C, which provides an explanation for Secondary Plans on the purpose and use of the benefit reserve and how Secondary Plans

calculate Claims. A copy of Appendix C is also available on the Louisiana Department of Insurance's website at https://www.ldi.la.gov/docs/default-source/documents/legaldocs/regulations/reg32appendixc.pdf?sfvrsn=24e14b52_0.

Summary
This is a summary of only a few of the provisions of *your* health Plan to help *you* understand Coordination of Benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language above, which determines *your* Benefits.

1. Double Coverage

   It is common for family members to be covered by more than one healthcare plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers. When *you* are covered by more than one health plan, state law permits *your* insurers to follow a procedure called "Coordination of Benefits" to determine how much each should pay when *you* have a Claim. The goal is to make sure that the combined payments of all Plans do not add up to more than *your* covered healthcare expenses. Coordination of Benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones.

2. Primary or Secondary

   You will be asked to identify all the Plans that cover members of *your* family. *We* need this information to determine whether *we* are the "primary" or "secondary" Benefit payer. The Primary Plan always pays first when *you* have a Claim. Any Plan that does not contain *your* state's COB rules will always be primary.

6. When this Plan is Primary

If *you* or a family member are covered under another Plan in addition to this one, *we* will be primary when:

a. The Claim is for *your* own healthcare expenses, unless *you* are covered by Medicare and both *you* and *your Spouse* are retired;
b. The Claim is for *your Spouse*, who is covered by Medicare, and *you* are not both retired;
c. The Claim is for the healthcare expenses of *your* child who is covered by this Plan and:
   i) *You* are married and *your* birthday is earlier in the year than *your Spouse*'s or *you* are living with another individual, regardless of whether or not *you* have ever been married to that individual, and *your* birthday is earlier than that other individual's birthday. This is known as the birthday rule;
   ii) *You* are separated or divorced and *you* have informed *us* of a court decree that makes *you* responsible for the child's healthcare expenses; or
   iii) There is no court decree, but *you* have custody of the child.

4. Other Situations

d. *We* will be primary when any other provisions of state or federal law require *us* to be. When *we* are the Primary Plan, *we* will pay the Benefits in accordance with the terms of *your* Contract, just as if *you* had no other healthcare coverage under any *other Plan*.
e. *We* will be secondary whenever the rules do not require *us* to be Primary. When *we* are the Secondary Plan, *we* do not pay until after the Primary Plan has paid its Benefits. *We* will then pay part or all of the Allowable Expenses left unpaid, as explained below. An "Allowable Expense" is a healthcare service or expense covered by one of the Plans, including *Copayments, Coinsurance* and *Deductibles*.
   v) If there is a difference between the amount the Plans allow, *we* will base *our* payment on the higher amount. However, if the Primary Plan has a Contract with the

Provider, *our* combined payments will not be more than the Contract calls for. Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) usually have Contracts with their Providers.

vi) *We* will determine *our* payment by subtracting the amount the Primary Plan paid from the amount *we* would have paid if *we* had been primary. *We* will use any savings to pay the balance of any unpaid Allowable Expenses covered by either Plan.

vii) If the Primary Plan covers similar kinds of healthcare expenses, but allows expenses that *we* do not cover, *we* will pay for those items as long as there is a balance in *your* benefit reserve, as explained below.

viii) *We* will not pay an amount the Primary Plan did not cover because *you* did not follow its rules and procedures. For example, if *your* Plan has reduced its Benefit because *you* did not obtain pre-certification, as required by that plan, *we* will not pay the amount of the reduction, because it is not an Allowable Expense.

f. Benefit Reserve

When *we* are secondary, *we* often will pay less than *we* would have paid if *we* had been primary. Each time *we* "save" by paying less, *we* will put that savings into a benefit reserve. Each family member covered by this Plan has a separate benefit reserve. *We* use the benefit reserve to pay Allowable Expenses that are covered only partially by both Plans. To obtain a reimbursement, *you* must show *us* what the Primary Plan has paid so *we* can calculate the savings. To make sure *you* receive the full Benefit or coordination, *you* should submit all Claims to each of *your* Plans. Savings can build up in *your* reserve for one year. At the end of the year any balance is erased, and a fresh benefit reserve begins for each person the next year as soon as there are savings on their Claims.

Right to receive and release needed information

Certain facts are needed to apply these COB rules. *We* have the right to decide which facts *we* need. *We* may get needed facts from or give them to any other organization or person. *We* need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Plan must give *us* any facts *we* need to pay the Claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this Plan. *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. To the extent, such payments are made; they discharge *Us* from further liability. The term “payment made” includes providing Benefits in the form of services, in which case the payment made will be deemed to be the reasonable cash value of any Benefits provided in the form of services.

Right of Recovery

If the amount of the payments that *We* made is more than it should have paid under this COB section, *We* may recover the excess. *We* may get such recovery or payment from one or more of:

1. The persons *we* have paid or whom *we* have paid;
2. Insurance companies; or
3. Other organizations.

The “amount of the payments made” includes the reasonable cash value of any Benefits provided in the form of services.

Claims

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

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 15 months from date services rendered will not be accepted.

Indemnity claims payable under this *policy* for any *loss* other than loss of time on account of disability will be paid *immediately* upon receipt of written proof of such *loss*. Subject to written *proof of loss*, accrued indemnity claims for loss of time on account of disability will be paid (insert period of payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid *immediately*.

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

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

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

To request reimbursement for a *covered service*, *you* need a copy of the detailed claim from *your provider*. *You* also need to submit an explanation of why *you* paid for the *covered services* along with the *member* reimbursement claim form posted at https://www.louisianahealthconnect.com/ under "Member Resources". Send all the documentation to *us* at the following address:

Ambetter from Louisiana Healthcare Connections
Attn: Claims Department
8585 Archives Avenue, Suite 310
Baton Rouge, LA 70809

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

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

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

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

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

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

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

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

Claims submitted for services received by a deceased *member* will be payable in accordance with the *beneficiary* designation and the provisions respecting such payments. If no such designation or provision is provided, claims will be payable to the estate of the *member*. Any other claims unpaid at the *member*'s death may, at *our* option, be paid to the *beneficiary*. All other claims will be payable to the *member* or to the *provider*, at *our* option.

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

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

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

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

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

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

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

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

Custodial Parent

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

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

4. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions, and limitations of the *policy*;
5. Accept claim forms and requests for claim payment from the custodial parent; and
6. 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.

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 one year after the date *proof of loss* is required.

Grievance, Appeal, and External Review Procedures

Internal Procedures

Grievance
Ambetter of Louisiana Healthcare Connections has a *grievance* procedure which allows the *member* the opportunity to resolve the *member's* issues and *complaints*. The process is voluntary and is available for review of the *policy*, quality of care or quality of service issues that affect the *member*. The *grievance* process does not apply to *complaints* based solely on the basis that the *policy* does not cover the service or limits benefits for the health care service in question, provided that the exclusion of the specific service requested is clearly stated in the *policy.*

Grievances are normally, but not limited to, the following concerns:

3. Availability, delivery, or quality of health care services, including a *complaint* regarding an *adverse determination* made pursuant to *utilization review*.
4. Claims payment, handling, or reimbursement for health care services.
   Matters pertaining to the contractual relationship between a *covered person* and a health insurance issuer.

Filing a Grievance
Grievances may be requested by a *member* or the *member's authorized representative*. *Grievances* may be filed orally by calling 1-866-595-8133 (TTY/TDD 711) or in writing by mailing *us* a letter or the Grievance and Appeal Form from *our* website to:

Ambetter from Louisiana Health Care Connections
PO Box 10341
Van Nuys, CA 91410
1-833-886-7956

A *member* or the *member's authorized representative* has the right to submit written comments, documents, records, and other information relating to the claim for benefits, and the right to review the claim file and to present evidence and testimony as part of the internal review process.

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

An eligible grievant is:

4. A *member*;
5. Person authorized (orally or in writing) to act on behalf of the *member*. **Note:** Written *authorization* is not required; however, if received, *we* will accept any written expression of *authorization* without requiring specific form, language, or format;
6. In the event the *member* is unable to give consent: a *spouse*, family member, or the treating *provider*.

   Important: *Adverse determinations* that are not *grievances* will follow standard Patient Protection and Affordable Care Act (PPACA) internal *appeals* procedures.

Acknowledgement
Within 5 business days of receipt of a *grievance*, a written acknowledgment to the *member* or the *member's authorized representative* confirming receipt of the *grievance* must be delivered or deposited in the mail.

When acknowledging a *grievance* filed by an *authorized representative*, the acknowledgement shall include

a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.

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

Resolution Timeframes
We will issue a written decision, in clear terms, to the *member* and *authorized representative*, if applicable, within 30 calendar days after receiving the *grievance*.

Right to Participate
A *member* or the *member's authorized representative*, who has filed a *grievance* has the right to submit comments to the Grievances and Appeals Department. The *member* or *authorized representative* is entitled to request a copy of documentation reviewed by the Grievances and Appeals Department in making its determination.

Written Grievance Response
Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reasons for the denial, determination, or initiation of disenrollment.

Our written decision to the *member* must include:
7. The disposition of and the specific reason or reasons for the decision;
8. Any corrective action taken on the *grievance;*
9. A written description of position titles of the persons involved in making the decision;
10. A clear explanation of the decision;
11. A statement that the *member* is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *member* 's claim for benefits; and
12. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse determination*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse determination* and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the *member* upon request.

Appeals
When *we* deny a claim for a treatment or service, a claim for plan benefits the *member* has already received (*post-service claim* denial) or *we* deny the *member's* request to authorize treatment or service (pre-service denial), *our* decision is known as an *adverse determination*. The *member*, their *physician* or *authorized representative* can request an *appeal* of *our* decision. If *we* rescind the *member's* coverage or deny the *member's* application for coverage, the *member*, their *physician* or *authorized representative* may also *appeal our* decision. When *we* receive an *appeal*, *we* are required to review *our* own decision.

Filing an Appeal
Appeals must be filed in writing by completing the Grievance and Appeal Form from *our* website or sending a written *appeal* along with copies of any supporting documents and mailed or faxed to:

Time Limits for filing an appeal
The *member* or *authorized representative* must file the internal *appeal* within 180 calendar days of the receipt of the notice of denial (an *adverse determination*). Failure to file within this time limit may result in the company's declining to consider the *appeal*.

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

An eligible appellant is:

5. A *member;*
6. Person authorized to act on behalf of the *member*. **Note:** Written authorization is required;
7. In the event the *member* is unable to give consent: a *spouse*, family member, or the treating *provider*; or
8. In the event of an *expedited appeal*: the person for whom the insured has verbally given authorization to represent the appellant.

Acknowledgement:
Within 5 business days of receipt of an *appeal*, a written acknowledgment to the *member*, the *provider* or the *member's authorized representative* confirming receipt of the *appeal* must be delivered or deposited in the mail.

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

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

Resolution Timeframes:
Appeals will be resolved and *we* will notify the *member* in writing with the *appeal* decision within the following timeframes:

3. *Post-service claim*: within 60 calendar days after receipt of the request for internal *appeal*; or
4. *Pre-service claim*: within 30 calendar days after receipt of the request for internal *appeal*.

In general, Ambetter of Louisiana Healthcare Connections may seek *member's approval* to extend the time for providing a decision for 14 calendar days after the expiration of the initial period, or if the plan determines that such an extension is necessary for reasons beyond the control of the plan. There is no provision for extensions in the case of claims involving urgent care or *expedited appeals*.

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

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

Expedited Appeal
An *expedited appeal* may be submitted orally or in writing. If submitted orally, the request must be followed by a brief written *appeal*. All necessary information, including *our* determination on review, will be transmitted between the *member* and *us* by telephone, facsimile, or other available similarly expeditious method. An *expedited appeal* shall be resolved as expeditiously as the *member*'*s* health condition requires, but not more than 72 hours after receipt of the *appeal*.

An *expedited appeal* means an *appeal* where any of the following applies:

3. The duration of the standard resolution process will result in serious jeopardy to the life or health of the *member* or the ability of the *member* to regain maximum function.
4. In the opinion of a *provider* with knowledge of the *member's* medical condition, the *member* is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *appeal*.

If the *expedited appeal* involves an *adverse determination* with respect to a concurrent review of an urgent care request, the service shall be continued until the *covered person* or *covered person's authorized representative* has been notified of the determination or until the healthcare *provider* determines that the urgent care is no longer appropriate or necessary. This does not apply to requests for extensions.

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

Simultaneous *expedited appeal* and external review
The *member* or *authorized representative*, may request an *expedited appeal* and an expedited external review (see External Review provision) if both the following apply:

3. The *member* filed a request for an *expedited appeal*; and
4. After a *final adverse determination*, if any of the following apply:
    a. The *member's* treating *physician* certifies that the *adverse determination* involves a medical condition that could seriously jeopardize the *member's life or health*, or would jeopardize the *member's* ability to regain maximum function, if treated after the timeframe of a standard external review;
    b. The *final adverse determination* concerns an admission, availability of care, continued stay or health care service for which the *member* received emergency services, but has not yet been discharged from a facility.

c. The *final adverse determination* involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is *experimental or investigational* and the *covered person's* treating *physician* certifies in writing that any delay in *appealing* the *adverse determination* may pose an imminent threat to the *covered person's* health, including but not limited to severe pain, potential loss of life, limb, or major bodily function, or the immediate deterioration of the health of the *covered person*.

Right to Participate
A *member* or the *member's authorized representative*, who has filed an *appeal* has the right to submit written comments, documents, records and other information to the Grievances and Appeals Department. The *member* or *member's authorized representative* is entitled to request a copy of the documentation reviewed by the Grievances and Appeals Department in making its determination. The *member* must submit questions or comments to the Grievances and Appeals Department in writing within a period of time provided in the notice to the *member* of the *appeals* process.

Continuing Coverage
The plan cannot terminate a *member's* benefits until the *member's appeal* rights have been exhausted. However, if the plan's decision is ultimately upheld, the *member* may be responsible to pay any outstanding claims or reimburse the plan for claim payments it made during the time of the *appeals*.

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

Rescission of coverage
If the plan rescinds the *member's* coverage, the *member* may file an *appeal* of that determination. The plan cannot terminate a *member's* benefits until the *member's appeal* rights have been exhausted. Since a *rescission* means that no coverage ever existed, if the plan's decision to rescind is upheld, the *member* will be responsible for payment of all claims for health care services.

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

Written Appeal Response
Appeal response letters will be written in a manner to be understood by the *member* and the notification shall include the specific reasons for the denial, determination, or initiation of disenrollment.

Our written decision (for an *adverse determination appeal*) will include:

12. The disposition of and the specific reason or reasons for the decision in clear terms and the medical rationale for the decision, if applicable
13. Any corrective action taken on the *appeal*;
14. The titles and qualifying credentials of the persons involved in making the decision;
15. A statement of the reviewer's understanding of the issues;
16. Reference to the evidence or documentation used as the basis for the decision
17. Reference to the specific plan or *contract* provision on which the determination is based;
18. A statement that the *member* is entitled to receive, upon request and free of charge, reasonable access to and, copies of all documents, records and other information relevant to the *member's* issue;

19. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the *adverse determination*, either the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the *adverse determination* and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the *member* upon request;
20. If the *adverse determination* is based on *medical necessity* or *experimental treatment* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the *member's* medical circumstances or a statement that such explanation will be provided free of charge upon request;
21. A description of the procedures for obtaining an external review of the *final adverse determination*; and
22. If applicable:
    a. Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse determination*;
    b. The date of service;
    c. The health care *provider's* name;
    d. The claim amount;
    e. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
    f. Ambetter of Louisiana Healthcare Connections' denial code with corresponding meaning;
    g. A description of any standard used, if any, in denying the claim;
    h. A description of the external review procedures, if applicable;
    i. The right to bring a civil action under state or federal law;
    j. A copy of the form that authorizes Ambetter of Louisiana Healthcare Connections to disclose protected health information, if applicable;
    k. That assistance is available by contacting the Louisiana Department of Insurance, if applicable; and
    l. A culturally linguistic statement based upon the *member's* county or state of *residence* that provides for oral translation of the *adverse determination*, if applicable.

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

External Review
An external review decision is binding on *us*. An external review decision is binding on the *member* except to the extent the *member* 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.

Applicability/Eligibility
The external review procedures apply to:
3. Any *hospital* or medical policy or certificate; excluding accident only or disability income only insurance; or
4. Conversion plans.

After exhausting the internal *appeal* process, the *member* has four (4) months to make a written request to the Grievances and Appeals Department for an external review after the date of receipt of *our* internal response.
6. If Ambetter of Louisiana Healthcare Connections has not issued a written decision to the *member* or his *authorized representative* within thirty (30) calendar days following the date the *member* or *authorized representative* files the *appeal* and the *member* or *authorized representative* has not

requested or agreed to a delay, the *member* or *authorized representative* may file a request for external review and shall be considered to have exhausted the health insurance issuer's internal claims and *appeals* process.

7. The internal *appeal* process must be exhausted before the *member* may request an external review unless the *member* files a request for an expedited external review at the same time as an internal *expedited appeal* or *we* either provide a waiver of this requirement or fail to follow the *appeal* process;
8. A *member* may make a request for an expedited external review with the plan at the time the *member* receives:
    a. An *adverse determination* if the determination involves a medical condition of the *member* for which the timeframe for completion of an internal *appeal* would seriously jeopardize the life or health of the *member* or would jeopardize the *member's* ability to regain maximum function and the *member* has filed a request for an internal *expedited appeal*; and
    b. A *final internal adverse determination*, if the *member* has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the *member* or would jeopardize the *member's* ability to regain maximum function, or if the *final internal adverse determination* concerns an admission, availability of care, continued stay, or health care item or service for which the *member* received *emergency* services, but has not been discharged from a facility; and
9. *Members* may request an expedited external review at the same time the internal *expedited appeal* is requested if:
    a. if the *member* has a medical condition in which the time frame for completion of an expedited review of the *appeal* involving an *adverse determination* would seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function; or
    b. if the *adverse determination* involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is *experimental or investigational* and the *member's* treating *physician* certifies in writing that any delay in *appealing* the *adverse determination* may pose an imminent threat to the *member's* health, including but not limited to severe pain, potential loss of life, limb, or major bodily function, or the immediate deterioration of the health of the *covered person*.
10. Upon receipt of a request for an expedited external review at the same time the internal *expedited appeal* is requested, the independent review organization conducting the external review will determine whether the *member* is required to complete the expedited *appeal* process with *us* first before it conducts the expedited external review.

An external review is available for *appeals* that involve:

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

External Review Process

11. *We* have five (5) business days (*immediately* for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether all of the following have been met:
    a. The individual was a *covered person* at the time the item or service was requested or, in the case of a retrospective review, was a *covered person* in the health benefit plan at the time the health care service was provided;
    b. The health care service is the subject of an *adverse determination* or a *final adverse determination*;

c. The *member* has exhausted the internal *appeal* process, unless the *covered person* is not required to exhaust the health insurance issuer's internal claims and *appeals* process; and
d. The *member* has provided all of the information and forms required to process an external review.

12. Within five (5) business days (*immediately* for expedited) after completion of the preliminary review, *we* will notify the commissioner and the *member* and, if applicable, the *authorized representative* in writing whether:
    a. The request is complete.
    b. The request is eligible for external review.
    c. If the request is not complete, inform the *covered person* and, if applicable, the *authorized representative* what information or materials are needed to make the request complete.
    d. If the request is not eligible for external review, inform the *covered person* and, if applicable, the *authorized representative* the reasons for its ineligibility. The *covered person* and, if applicable, the *authorized representative* may *appeal our* initial determination to the commissioner of insurance.
13. *We* will notify the commissioner when a request is eligible for external review by submitting a request for assignment of an IRO through the Department of Insurance's website. Upon notification, the commissioner shall do the following:
    a. Randomly assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner to conduct the external review and notify *us* of the name of the assigned IRO.
    b. Within one (1) business day, send written notice to the *covered person* and, if applicable, the *authorized representative*, of the request's eligibility and acceptance for external review and the identity and contact information of the assigned IRO. The notice will also state *covered person* and, if applicable, the *authorized representative* may submit in writing to the assigned IRO, within five (5) business days following the date of receipt of the notice, any additional information that the IRO should consider when conducting the external review. The IRO shall be authorized but not required to accept and consider additional information submitted after five (5) business days.
14. Within five (5) business days after the date of assignment of the IRO, *we* must provide the documents and any information considered in making the *adverse determination* to the IRO. **Note:** For expedited, after assignment of the IRO, *we* must provide the documents and any information considered in making the *adverse determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method;
15. If *we* fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the *adverse determination*;
16. Upon receipt of any information submitted by the *member*, the IRO must forward the information to *us* within one (1) business day;
17. Upon receipt of the information, *we* may reconsider *our* determination. If *we* reverse *our adverse determination*, *we* must provide written notice of the decision to the *member* and the IRO within one (1) business day after making such decision. The external review would be considered terminated;
18. Within one (1) business day after making the decision to reverse an *adverse determination* or *final adverse determination*, *we* will notify the *covered person*, if applicable, the *authorized representative*, the assigned IRO, and the commissioner in writing of *our* decision. The assigned IRO will terminate the external review upon receipt of the notice sent by *us*.
19. Within 45 calendar days for external review requests related to medical necessity determinations or 41 days for external review requests related to services denied as *experimental or investigational* (as expeditiously as medical condition or circumstances requires, but in no event more than 72 hours for expedited medical necessity denials and as soon as possible, but no longer than 8 days for expedited *experimental or investigational* denials) after the date of receipt of the request for an external review by the health plan, the IRO will review all of the information and provide written

notice of its decision to uphold or reverse the *adverse determination* to the *covered person*, if applicable, the *authorized representative*, the commissioner, and to *us*; and

20. Upon receipt of a notice of a decision by the IRO reversing the *adverse determination* or *final adverse determination*, *we* will *immediately* approve the coverage or payment that was the subject of the *adverse determination* or *final adverse determination.*

Expedited External Review

Ambetter will allow a *member* to make a request for an expedited external review with the plan at the time the *member* receives:

a. An *adverse determination* if both of the following apply:
    i. If the determination involves a medical condition of the *member* for which the timeframe for completion of an internal *expedited appeal* would seriously jeopardize the life or health of the *member* or would jeopardize the *member's* ability to regain maximum function; and
    ii. The *covered person* or *authorized representative* has filed a request for an expedited review for an *appeal* involving an *adverse determination*.
b. A *final adverse determination* if either of the following applies:
    i. The *covered person* has a medical condition in which the time frame for completion of a standard external review would seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function.
    ii. The *final adverse determination* concerns an admission, availability of care, continued stay, or health care service for which the *covered person* received emergency services, but has not been discharged from a facility.

An expedited external review will not be provided for retrospective *adverse determinations* or retrospective *final adverse determinations*.

Members may request assistance with all levels of the *appeal* process from the Louisiana Department of Insurance's office of consumer advocacy. The office of consumer advocacy may be contacted at:

Office of Consumer Advocacy
Louisiana Dept. of Insurance
P. O. Box 94214
Baton Rouge, LA 70804-9214
1-225-342-5900 or 1-800-259-5300

The *member* may also view their *grievance* and *appeal* information in their *Member* Secure Portal.

General Provisions

Entire Contract
This *policy,* the application, expressing the entire money and other consideration for *coverage*, the *schedule of benefits*, and any amendments or endorsements make up the entire *contract* between *you* and *us.* No agent may:

5. Change this *policy*;
6. Waive any of the provisions of this *policy*;
7. Extend the time for payment of premiums; or
8. Waive any of *our* rights or requirements.

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

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

4. The misrepresented fact is contained in a written application, including amendments, signed by a *member*;
5. A copy of the application, and any amendments, has been furnished to the *member(s),* or to their *beneficiary*; and
6. 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.

In such event, *we* will give *you* 30 days' advance written notice and will include the reason for *rescission*. *Rescission* could be retroactive to the *effective date* of coverage.

Repayment for Fraud, Misrepresentation or False Information
After three years from the date of issue of this *policy*, no misstatements, except fraudulent misstatements, made by the applicant in the application for such *policy* shall be used to void the *policy* or to deny a claim based upon such misstatement. During the first three years a *member* is covered under the *policy*, if a *member* makes a misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *policy* or in filing a claim for *policy* benefits, *we* have the right to demand that *member* pay back to *us* all benefits that *we* provided or paid during the time the *member* was covered under the *policy*.

Change in Premium Amount

6. This *policy* will expire December 31, 2022. This *policy* is renewable at *your* option for the *policy year* beginning January 1, 2023. Any renewal of this *policy* for the *policy year* that begins on January 1, 2023 will be subject to premium changes based on the rates that apply.
7. Except as provided in the following paragraph, *we* will give *you* 45 days written notice of a premium change, at *your* last address shown in *our* records. Any change in premium will become effective on the date specified in the notice. If *you* continue to pay *your* premiums, *you* show that *you* accept the change.
8. Premiums are guaranteed for the *policy year*. However, *we* reserve the right to change premiums more often due to a change in the extent or nature of the risk that was not previously considered in the rate determination process at any time during the life of the *policy*. This risk includes the

addition of a newly *covered person*. Additionally, *we* reserve the right to change the premium if *you* request a change in benefits from that which was in force at the time of the last rate determination.

9. If *your* age was misstated, any amount payable or any indemnity accruing under this Contract will be such as the premium paid would have purchased at the correct age. A clerical error will not void insurance which should be in force nor will it continue insurance which should have ended.
10. If non-tobacco premiums are charged when tobacco premiums should have been charged, *we* may retroactively adjust the premium and collect the appropriate premium.

Applicable Law and Conforming Policy

This *policy* will be governed and construed according to the laws and regulations of the State of Louisiana except when preempted by federal law. This *policy* is not subject to regulation by any state other than the State of Louisiana. This *policy* will conform to the *Essential Health Benefits* package and requirements. If any provision of this *policy* conflicts with any law of the State of Louisiana or the United States of America that applies, the *policy* will be automatically amended to meet the minimum requirements of the law. Any legal action filed against *us* must be filed in the appropriate court in the State of Louisiana.

Extension of Time Limitations

If any limitation of this *policy* with respect to giving notice of claim, furnishing *proof of loss*, or bringing any action on this *policy* is less than that permitted by law of the state, district or territory in which the insured resides at the time this *policy* is issued, such limitation is hereby extended to agree with the minimum period permitted by such law.

Continuity of Care

You have the right to continuity of care that applies to the following provisions and subject to consent of the treating Provider:

5. If *you* have been diagnosed with a *life-threatening illness*.
6. If *you* have been diagnosed with *serious acute condition*.
7. If *you* have been diagnosed as being in a high-risk *pregnancy* or are past the 24th week of *pregnancy*, *you* can continue receiving *Covered Services* through delivery and postpartum care related to the *pregnancy* and delivery.
8. If *you* are currently within an ongoing course of treatment for a health condition for which a treating *provider* attests that discontinuing care by that *provider* would worsen the condition or interfere with anticipated outcomes.

The provisions of continuity of care do not apply if any of the following occurs:

5. The reason for termination of a *provider*'s contractual agreement is a result of documented reasons relative to quality of care, or the suspension, revocation or applicable restriction of the license to practice in Louisiana by the Louisiana State Board of Medical Examiners.
6. *You* voluntarily choose to change *providers*.
7. *You* move outside of the geographic *service area* of the *provider*.
8. *Your* chronic condition only requires routine monitoring and is not in an acute phase of the condition.

Personal Health Information (PHI)

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

We protect all oral, written and electronic PHI. *We* follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. *We* are required to notify *you* about these practices every year. This notice describes how *your* medical information may be used and disclosed and how *you* can get access to this information. Please review it carefully. If *you* need more information or would like the complete notice, please visit https://www.louisianahealthconnect.com/ or call *Member* Services at 1-866-595-8133 (TTY/TDD 711).

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

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

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de [Health Plan Name], tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al [Health Plan Phone].
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'[Health Plan Name], vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez-le [Health Plan Phone].
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về [Health Plan Name] , 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 [Health Plan Phone].
Chinese:	如果您，或是您正在協助的對象，有關於 [Health Plan Name] 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 [Health Plan Phone]。
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول[Plan Name Health]، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ [Phone Health Plan].
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa [Health Plan Name], may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa [Health Plan Phone].
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 [Health Plan Name]에 관해서 질문이 있다면 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 [Health Plan Phone]번으로 전화하십시오.
Portuguese:	Se você ou alguém que estiver a ajudar tiver dúvidas sobre a [health plan name], tem o direito de obter ajuda e informações no seu idioma gratuitamente. Para falar com um intérprete, ligue para [health plan phone #].
Laotian:	ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ [Health Plan Name], ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ ໃຫ້ໂທຫາ [Health Plan Phone].
Japanese:	Health Plan Name 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、[Health Plan Phone] までお電話ください。
Urdu:	اگر [Health Plan Name] کے بارے میں آپ کے، یا جن کی آپ مدد کر رہے ہیں، ان کے سوالات ہوں تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی مترجم سے بات کرنے کے لیے [Health Plan Phone] پر کال کریں۔
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu [Health Plan Name] 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 [Health Plan Phone] an.
Persian:	اگر شما، یا کسي که به او کمک مي کنید سؤالي در مورد [Name Health Plan] دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. برای صحبت کردن با مترجم با شماره [Health Plan Phone] تماس بگیرید.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования [Health Plan Name] вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону [Health Plan Phone].
Thai:	หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีคำถามเกี่ยวกับ [health plan name] ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข [health plan phone #].

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Statement of Non-Discrimination

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

Ambetter from Louisiana Healthcare Connections Inc.:

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

If *you* need these services, contact Ambetter from Louisiana Healthcare Connections Inc. at 1-833-635-0450 (TTY 711).

If *you* believe that Ambetter from Louisiana Healthcare Connections Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, *you* can file a *grievance* with: Ambetter from Louisiana Healthcare Connections Inc., Attn: Appeals and Grievances PO Box 10341 Van Nuys CA, 91410, 1-833-635-0450 (TTY 711), Fax 1-833-886-7956. *You* can file a *grievance* by mail, fax, or email. If *you* need help filing a *grievance*, Ambetter from Louisiana Healthcare Connections Inc. is available to help *you*. *You* can also file a civil rights *complaint* with the U.S Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

Declaración de no discriminación

Ambetter de Louisiana Healthcare Connections cumple con las leyes federales de derechos civiles aplicables y no discrimina en base a raza, color, origen nacional, edad, discapacidad o sexo. Ambetter from Louisiana Healthcare Connections no excluye a las personas ni las trata de manera distinta debido a su raza, color, origen nacional, edad, discapacidad o sexo.

Ambetter de Louisiana Healthcare Connections:

- Ofrece ayudas y servicios gratuitos a personas con discapacidades para que se comuniquen eficazmente con nosotros, como:
  - Intérpretes de lenguaje de señas calificados
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Ofrece servicios gratuitos de idiomas a las personas cuyo idioma principal no es el inglés, tales como:
  - Intérpretes calificados
  - Información escrita en otros idiomas

Si necesita estos servicios, comuníquese con Ambetter de Louisiana Healthcare Connections, 1-833-635-0450 (TTY 711).

Si cree que Ambetter de Louisiana Healthcare Connections no le ha brindado estos servicios o le ha discriminado de otra manera por motivos de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja ante: Ambetter from Louisiana Healthcare Connections, Appeals and Grievances, PO Box 10341 Van Nuys CA, 91410, 1-833-635-0450 (TTY 711), Fax 1-833-886-7956. Usted puede presentar una queja por correo, fax, o por correo electrónico. Si necesita ayuda para presentar una queja, Ambetter from Louisiana Healthcare Connections está disponible para usted. Además puede presentar un reclamo de derechos civiles al U.S. Department of Health and Human Services (Departamento de Salud y Servicios Humanos de EE.UU.), Office for Civil Rights (Oficina de Derechos Civiles) electrónicamente a través del Portal para reclamos de la Oficina de Derechos Civiles, disponible en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* o por correo o teléfono en: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD).

Los formularios de reclamo están disponibles en *http://www.hhs.gov/ocr/office/file/index.html.*