

2022 Evidence of Coverage



AmbetterofOklahoma.com

AMBETTER OF OKLAHOMA

Home Office: 14000 Quail Springs Parkway, Suite 650, Oklahoma City, OK 73134

Major Medical Expense Insurance Policy

In this *policy*, the terms "*you*", "*your*" or "*yours*" will refer to the *covered person* or any *dependents* enrolled in this *policy*. The terms "*we*", "*our*" or "*us*" will refer to Ambetter of Oklahoma.

AGREEMENT AND CONSIDERATION

This document along with the corresponding *Schedule of Benefits* is *your policy* and it is a legal document. It is the agreement under which benefits will be provided and paid. In consideration of *your* application and the timely payment of premiums, *we* will provide benefits to *you*, the *covered person*, 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 *policy* 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 45 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 policies 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. Benefits may be reduced or not covered if the requirements are not met. Please refer to the *Schedule of Benefits* and the *Prior Authorization* section.

TEN DAY RIGHT TO RETURN POLICY

Please read *your policy* carefully. If *you* are not satisfied, return this *policy* to *us* or to *our* agent within 10 days after *you* receive it. All premiums paid will be refunded, less claims paid, and the *policy* will be considered null and void from the *effective date*. If *we* do not refund the premiums paid within 30 days of the cancellation request, *we* will pay interest on those proceeds as required by state law.

Ambetter of Oklahoma

A handwritten signature in black ink, appearing to read 'Kevin J. Counihan', with a stylized, flowing script.

Kevin J. Counihan
President

**SPECIAL NOTICE OF PROTECTION PROVIDED BY
OKLAHOMA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

THIS NOTICE PROVIDES A BRIEF SUMMARY OF THE OKLAHOMA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ("THE ASSOCIATION") AND THE PROTECTION IT PROVIDES FOR POLICYHOLDERS. THIS SAFETY NET WAS CREATED UNDER OKLAHOMA LAW, WHICH DETERMINES WHO AND WHAT IS COVERED AND THE AMOUNTS OF COVERAGE. THE ASSOCIATION WAS ESTABLISHED TO PROVIDE PROTECTION IN THE UNLIKELY EVENT THAT YOUR LIFE, ANNUITY OR HEALTH INSURANCE COMPANY BECOMES FINANCIALLY UNABLE TO MEET ITS OBLIGATIONS AND IS TAKEN OVER BY ITS INSURANCE DEPARTMENT. IF THIS SHOULD HAPPEN, THE ASSOCIATION WILL TYPICALLY ARRANGE TO CONTINUE COVERAGE AND PAY CLAIMS, IN ACCORDANCE WITH OKLAHOMA LAW, WITH FUNDING FROM ASSESSMENTS PAID BY OTHER INSURANCE COMPANIES.

THE BASIC PROTECTIONS PROVIDED BY THE ASSOCIATION ARE:

- **LIFE INSURANCE**
- **\$300,000 IN DEATH BENEFITS**
- **\$100,000 IN CASH SURRENDER OR WITHDRAWAL VALUES**

- **HEALTH INSURANCE**
- **\$500,000 IN HOSPITAL, MEDICAL AND SURGICAL INSURANCE BENEFITS**
- **\$300,000 IN DISABILITY INCOME INSURANCE BENEFITS**
- **\$300,000 IN LONG-TERM CARE INSURANCE BENEFITS**
- **\$100,000 IN OTHER TYPES OF HEALTH INSURANCE BENEFITS**
- **ANNUITIES**
- **\$300,000 IN WITHDRAWAL AND CASH VALUES**

THE MAXIMUM AMOUNT OF PROTECTION FOR EACH INDIVIDUAL, REGARDLESS OF THE NUMBER OF POLICIES OR CONTRACTS, IS \$300,000, EXCEPT THAT WITH REGARD TO HOSPITAL, MEDICAL AND SURGICAL INSURANCE BENEFITS, THE MAXIMUM AMOUNT THAT WILL BE PAID IS \$500,000.

NOTE: CERTAIN POLICIES AND CONTRACTS MAY NOT BE COVERED OR FULLY COVERED. FOR EXAMPLE, COVERAGE DOES NOT EXTEND TO ANY PORTION(S) OF A POLICY OR CONTRACT THAT THE INSURER DOES NOT GUARANTEE, SUCH AS CERTAIN INVESTMENT ADDITIONS TO THE ACCOUNT VALUE OF A VARIABLE LIFE INSURANCE POLICY OR A VARIABLE ANNUITY CONTRACT. THERE ARE ALSO VARIOUS RESIDENCY REQUIREMENTS AND OTHER LIMITATIONS UNDER OKLAHOMA LAW.

TO LEARN MORE ABOUT THE ABOVE PROTECTIONS, PLEASE VISIT THE ASSOCIATION'S WEBSITE AT WWW.OKLIFEGA.ORG, OR CONTACT: OKLAHOMA LIFE & HEALTH INSURANCE GUARANTY ASSOCIATION 201 ROBERT S. KERR, SUITE 600 OKLAHOMA CITY, OK 73102 PHONE (405) 272-9221

OKLAHOMA DEPARTMENT OF INSURANCE 400 NE 50TH STREET OKLAHOMA CITY, OK 73105 1-800-522-0071 OR (405) 521-2828

TABLES OF CONTENTS

INTRODUCTION	6
MEMBER RIGHTS AND RESPONSIBILITIES	7
IMPORTANT INFORMATION	10
DEFINITIONS	12
DEPENDENT MEMBER COVERAGE	28
ONGOING ELIGIBILITY	30
PREMIUMS	34
PRIOR AUTHORIZATION	36
COST SHARING FEATURES	38
ACCESS TO CARE	40
MAJOR MEDICAL EXPENSE BENEFITS	43
Ambulance Service Benefits	43
Air Ambulance Service Benefits	43
Autism Spectrum Disorder Benefits	44
Chiropractic Services	45
Clinical Trial Coverage	45
Colorectal Cancer Examinations and Laboratory Tests	46
Contraception	46
Diabetic Care	46
Durable Medical Equipment (DME), Prosthetics, and Orthotic Devices	47
Emergency Room Services	51
Habilitation Expense Benefits	51
Home Health Care Service Expense Benefits	51
Hospice Care Service Expense Benefits	52
Hospital Benefits	52
Infertility	52
Mammography Screening	53
Maternity Care	53
Medical Foods and Nutritional Services	54
Medical and Surgical Expense Benefits	54
Mental Health and Substance Use Disorder Benefits	55
Other Dental Services	57
Outpatient Medical Supplies Expense Benefits	57
Pediatric Vision Benefits – Children under the age of 19	57
Prescription Drug Expense Benefits	58

Preventive Care Expense Benefits	63
Prostate Specific Antigen Testing	64
Radiology, Imaging and Other Diagnostic Testing	64
Rehabilitation and Extended Care Facility Expense Benefits.....	64
Second Medical Opinion	64
Skilled Nursing Facility Expense Benefits	65
Sleep Studies.....	65
Social Determinants of Health Supplemental Benefits.....	65
Transplant Expense Benefits.....	65
Urgent Care.....	68
Wellness Program Benefits.....	68
Care Management Programs	69
GENERAL NON-COVERED SERVICES AND EXCLUSIONS.....	70
TERMINATION.....	73
RIGHT OF REIMBURSEMENT	75
COORDINATION OF BENEFITS.....	77
CLAIMS	81
GRIEVANCE AND COMPLAINT PROCEDURES	84
GENERAL PROVISIONS	91

INTRODUCTION

Welcome to Ambetter of Oklahoma! *We* have prepared this *policy* to help explain *your* coverage. Please refer to this *policy* whenever *you* require medical services. It describes:

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

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

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

How to Contact Us

Ambetter of Oklahoma
14000 Quail Springs Parkway, Suite 650
Oklahoma City, OK 73134

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

Member Services **1-833-492-0679**

TDD/TTY line **711**

Fax **1-833-959-3364**

Emergency **911**

24/7 Nurse Advice Line **1-833-492-0679** or for the hearing impaired **TDD/TTY 711**

Interpreter Services

Ambetter of Oklahoma 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 1-833-492-0679 or for the hearing impaired TDD/TTY 711.

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting *you* as a *member*.
2. Encouraging open discussions between *you*, *your physician* and *medical practitioners*.
3. Providing information to help *you* become an informed healthcare consumer.
4. Providing access to *covered services* and *our network providers*.
5. Sharing *our* expectations of *you* as a *member*.
6. Providing coverage regardless of age, ethnicity, race, religion, gender, sexual orientation, national origin, physical or mental disability, 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, *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 ambetterofoklahoma.com. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* healthcare services. *You* can find any of *our network providers* by visiting *our* website and selecting the “Find a Provider” function. There *you* will have the ability to narrow *your* search by provider specialty, zip code, gender, languages spoken and whether or not they are currently accepting new patients. *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 printed copy of the Provider Directory at no charge by calling Member Services at 1-833-492-0679 (TDD/TTY: 711). In order to obtain benefits, *you* must designate a *primary care provider* for each *member*. *We* can help *you* pick a *primary care provider (PCP)*. *We* can make *your* choice of *primary care provider* effective on the next business day.

Call the *primary care provider's* office if *you* want to make an appointment. If *you* need help, call Member Services at 1-833-492-0679 (TDD/TTY: 711). *We* will help *you* make the appointment.

Member ID Card

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

The ID card will show *your* name, *member ID#* and *copayment amounts* required at the time of service. If *you* do not get *your* ID card within a few weeks after *you* enroll, please call Member Services at 1-833-492-0679 (TDD/TTY: 711). *We* will send *you* another card.

Website

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

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

Quality Improvement

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

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

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

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

Protection from Balance Billing

Under federal law, effective January 1, 2022, *non-network providers* or facilities are prohibited from *balance billing* health plan *members* for:

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

Please review the Access to Care and Major Medical Expense Benefit sections of this *policy* for detailed information.

DEFINITIONS

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

Wherever used in this *policy*:

Acute rehabilitation is *rehabilitation* for patients who will benefit from an intensive, multidisciplinary *rehabilitation* program. Patients normally receive a combination of therapies such as physical, occupational and speech therapy as needed and are medically managed by specially trained *physicians*. *Rehabilitation services* must be performed for three or more hours per day, five (5) to seven (7) days per week, while the *covered person* is confined as an *inpatient* in a *hospital, rehabilitation facility, or skilled nursing facility*.

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

Adverse benefit determination means a determination by *us* that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet *our* requirements for *medical necessity*, appropriateness, health care setting, level of care, effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

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

Allowed Amount (also see **Eligible Service Expense**) is the maximum amount *we* will pay a provider for a *covered service*. When a *covered service* is received from a *network provider*, the *allowed amount* is the amount the provider agreed to accept from *us* as payment for that particular service. In all cases, the *allowed amount* will be subject to *cost sharing* (e.g., *deductible, coinsurance and copayment*) per the *member's* benefits. This amount excludes 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 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. See *balance billing* and *non-network provider* definitions for additional information. If *you* are *balance billed* in these situations, please contact Member Services immediately at the number listed on the back of *your* ID card.

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

Appeal means a request by the *member* or their representative to reverse, rescind, or otherwise modify an *Adverse Benefit Determination*.

Applied Behavior Analysis (ABA) is the design, implementation, and evaluation of environmental modifications by a board-certified behavior analyst using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Authorization or authorized (also “*Prior Authorization*” or “*Approval*”) means *our* decision to approve the *medically necessity* or the appropriateness of care for a *member* by the *member’s PCP* or provider group. *Authorizations* are not a guarantee of payment.

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

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

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

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

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

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

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

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

Care Management is a program in which a registered nurse or licensed mental health professional, known as a case manager, assists a *member* through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and healthcare benefits available to a *member*.

Center of Excellence means a *hospital* that:

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

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

Coinsurance means the percentage of *covered 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*; and
2. An *emergency cesarean section* or a *non-elective cesarean 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*.

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

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

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

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

Covered expense or covered service means an expense or service that is:

1. Incurred while *your* or *your dependent's* insurance 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 and each eligible child*:

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

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

Custodial care includes but is not limited to the following:

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

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

Deductible amount or Deductible means the amount that *you* must pay in a *calendar year* for *covered 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 means *your lawful spouse or an eligible child*.

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

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

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

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption; or

4. A child for whom legal guardianship has been awarded to *you* or *your spouse*.

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

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

1. For *network providers*: When a *covered expense* 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 Oklahoma law, the *eligible service expense* is as follows:
 - a. When a *covered emergency service* or *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.
 - b. When a *covered service* is received from a *non-network* professional provider who renders *non-emergency services* at an in-network facility, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the *provider* as payment in full. If the provider has not agreed to accept a negotiated fee with *us* as payment in full, unless otherwise required by applicable law, the *eligible service expense* 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.
 - c. Except as provided under (2)(a) and (2)(b) above, when a *covered expense* is received from a *non-network provider*, the *eligible service expense* is determined based on the lowest amount of the following:
 - i. the negotiated fee that has been agreed upon by *us* and the provider;
 - ii. 100% of the fee Medicare allows for the same or similar services provided in the same geographical area;
 - iii. the fee established by *us* by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by *us*;
 - iv. the fee charged by the provider for the services; or
 - v. a fee schedule that *we* develop.*You* may be billed for the difference between the amount paid and the provider's charge.

Emergency (Medical, Behavioral Health, and Substance Use) Services means covered *inpatient* and *outpatient services* that are (1) furnished by a provider qualified to furnish these services and (2) needed to evaluate or stabilize an *emergency medical/behavioral health* condition. An *emergency medical/behavioral*

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

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

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

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*.

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

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

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 provider with knowledge of the claimant's medical condition, the claimant is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*; and
3. A provider 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 healthcare services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, we determine to be:

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*FDA*) regulation, regardless of whether the trial is subject to *FDA* oversight;
2. An *unproven service*;
3. Subject to *FDA* approval, and:
 - a. It does not have *FDA* approval;
 - b. It has *FDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation;
 - 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 *covered person*.
4. *Experimental or investigational* according to the provider's research protocols.

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

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 use, custodial care*, nursing care, or for care of *mental disorders* or the mentally incompetent.

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

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

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

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

Habilitative or Habilitation Services means services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition. These services may include physical, occupational and speech therapies, developmental services and *durable medical equipment* for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder.

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 *covered person*.

Home health care means care or treatment of an *illness* or *injury* at the *covered person'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 a *terminally ill covered person* and those of the *covered person's immediate family*.

Hospital means an institution that:

1. Operates as a *hospital* pursuant to law;
2. Operates primarily for the reception, care, and treatment of sick or injured persons as *inpatients*;
3. Provides 24-hour nursing service by registered nurses on duty or call;

4. Has staff of one or more *physicians* available at all times;
5. Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or in facilities available to it on a prearranged basis; and
6. Is not primarily a long-term care facility; a *skilled nursing facility*, nursing, rest, *custodial care*, or convalescent home; a halfway house, transitional facility, or *residential treatment facility*; a facility for wilderness or outdoor programs; or a similar establishment.

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

Illness means a sickness, disease, or disorder of a *covered person*.

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

Injury means accidental bodily damage sustained by a *covered person* 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* and 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 unit or area of a *hospital* that meets the required standards of the Joint Commission.

Intensive day rehabilitation means two or more different types of therapy provided by one or more *rehabilitation licensed practitioners* and performed for three (3) or more hours per day, five (5) to seven (7) days per week.

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

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 services*, as shown in the *Schedule of Benefits*. Please note: There are separate *maximum out-of-pocket* amounts for in *network* benefits versus out of *network* benefits.

After the *maximum out-of-pocket* amount is met for an individual, Ambetter pays 100% of *eligible service expenses* for that individual. The family *maximum out-of-pocket* amount is two times the individual *maximum out-of-pocket* amount. Both the individual and the family *maximum out-of-pocket* amounts are shown in the *Schedule of Benefits* (in *network* and out of *network*).

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*.

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, licensed mental health and *substance use* practitioners, nurse practitioners, audiologists, chiropractors, dentists, pharmacists, nurse anesthetists, optometrists, podiatrists, psychologists or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy*: acupuncturist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, *emergency medical technician*, naturopath, perfusionist, massage therapist or sociologist. With regard to medical

services provided to a *covered person*, 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 or **medical necessity** means *our* decision as to whether any medical service, item, supply or treatment *authorized* by a provider to diagnose and treat a *covered person's illness or injury* which:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to *generally accepted standards of medical practice*;
3. Is not *custodial care*;
4. Is not solely for the convenience of the provider or the *covered person*;
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 for non-emergency services means that the person is no longer experiencing further deterioration as a result of a prior *injury* or *illness* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*. Stabilize, with respect to an *emergency* medical condition, means to provide medical treatment of the condition as necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer to a *network* facility or discharge of the individual from a facility. See Ambulance Service Benefits section for additional information.

Member or **Covered Person** means an individual covered by the health plan including any enrollee, subscriber or policyholder.

Necessary medical supplies mean medical supplies that are:

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

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

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

Network eligible service expense 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 provider means any person or entity that has entered into a contract with Ambetter of Oklahoma to provide covered services to *members* enrolled under this *policy*, including but not limited to, hospitals,

specialty hospitals, urgent care facilities, *physicians*, pharmacies, laboratories and other health professionals within *our service area*.

Non-elective cesarean section means:

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

Non-network provider means a *medical practitioner, provider facility*, or other provider who is not contracted with the plan as a participating provider. Services received from a *non-network provider* are covered at a reduced amount from those services received from a *network provider*. Please refer to your *Schedule of Benefits*.

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

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 *covered person* is enrolled in Medicare. *Other plan* will not include Medicaid.

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

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

Outpatient surgical facility 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.

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.

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

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

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

Primary care provider or **PCP** means a provider who gives or directs health care services for *you*. *Primary care providers* includes a family practitioner, general practitioner, advanced practice registered nurses (APRN), physician assistant (PA), pediatrician, internist, obstetrician, gynecologist, or any other practice allowed under the *policy*. A *primary care provider* supervises, directs and gives initial care and basic medical services to *you* and is in charge of *your* ongoing care.

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

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

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

Provider facility means a *hospital, rehabilitation facility, 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 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 Marketplace, an individual who has been determined eligible to enroll through the 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*. 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*.

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

1. Is licensed by the state as a *rehabilitation facility*; and

2. Operates primarily to provide 24-hour *primary care* or *rehabilitation* of sick or *injured* persons as *inpatients*.

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

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

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

Rescission of a *policy* means a determination by an insurer to withdraw the coverage back to the initial date of coverage.

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

Residential treatment facility means a facility that provides, with or without charge sleeping accommodations, and:

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

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

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

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

Service area means a geographical area, made up of counties, where *we* have been *authorized* by the State of Oklahoma to sell and market *our* health plans. This is where the majority of *our network providers* are located where *you* will receive all of *your* health care services and supplies.

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

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

6. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing standards of medical practice for that condition.

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

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

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

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

Substance use or ***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 *covered person's illness* or *injury* by manual or instrumental operations, performed by a provider while the *covered person 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*.

Synchronization means the coordination of medication refills for a patient taking two or more medications for one or more chronic conditions such that the patient's medications are refilled on the same schedule for a given time period.

Telehealth or ***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.

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 *covered person* has six (6) months or less to live.

Third party means a person or other entity that is or may be obligated or liable to the *covered person* for payment of any of the *covered person'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 *covered person* is entitled to benefits as a named insured person or an insured *dependent* 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 *covered person*, 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; and
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 *covered person's* health; and
2. As a result of an unforeseen *illness, injury*, or the onset of acute or severe symptoms.

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

DEPENDENT MEMBER COVERAGE

Dependent Eligibility

Your dependents become eligible for insurance on the latter of:

1. The date *you* became covered under this *policy*; or
2. The date of marriage to add a *spouse*; or
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* will be the same date as *your* initial coverage date. Only *dependents* included in the application for this *policy* will be covered on *your effective date*.

Coverage for a Newborn Child

An *eligible child* born to *you* or a family *member* will be covered from the time of birth until the 31st day after its birth. 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. Notice of the newborn must be given to *us* within 31 days after the date of birth in order to have the coverage continue after the 31 day period and will require payment of the additional premium. 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 contract may not deny coverage of the child due to failure to notify *us* of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st day after its birth, unless *we* have received notice from the entity that *you* have enrolled with (either the Health Insurance Marketplace or *us*).

Coverage for an Adopted Child

An adopted child of a *covered person* shall be covered from the date of the filing of a petition for adoption if (1) the *covered person* applies for coverage within sixty (60) days after the filing of the petition for adoption and where the issuer is notified by the Marketplace and (2) premium billed for this 60-day period is timely paid under the terms of this *policy* and its grace period after such application. However, the coverage shall begin from the moment of birth if (1) the petition for adoption and application for coverage is filed within sixty (60) days after the birth of the child, and (2) premium billed for this 60-day period is timely paid under the terms of this *policy* and its grace period after such application. 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*.

Unless an application is received within 60 days of petition of adoption, and premium is timely paid for the first 60 days under the terms of this *policy* and its grace period, coverage for the adopted child will not be effective and the adopted child cannot be enrolled until the next open enrollment period. Coverage for an adopted child shall terminate upon the dismissal or denial of a petition for adoption.

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

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

Adding Other Dependent Members

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

Prior Coverage

If a *member* is confined as an *inpatient* in a *hospital* on the *effective date* of this agreement, and prior coverage terminating immediately before the *effective date* of this agreement furnishes benefits for the hospitalization after the termination of prior coverage, then services and benefits will not be covered under this agreement for that *member* until the *member* is discharged from the *hospital* or benefits under the prior coverage are exhausted, whichever is earlier.

If there is no prior coverage or no continuation of *inpatient* coverage after the *effective date*, *your* Ambetter coverage will apply for covered benefits related to the *inpatient* coverage after *your effective date*. Ambetter coverage requires *you* notify Ambetter within 2 days of *your effective date* so *we* can review and authorize *medically necessary* services. If services are at a non-contracted *hospital*, claims will be paid at the Ambetter allowable and *you* may be billed for any balance of costs above the Ambetter allowable.

ONGOING ELIGIBILITY

For All Covered Persons

A *covered person's* eligibility for insurance under this *policy* will cease on the earlier of:

1. The date that a *covered person* has failed to pay premiums or contributions in accordance with the terms of this *policy* or the date that *we* have not received timely premium payments in accordance with the terms of this *policy*; or
2. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or
3. The date of termination that the Marketplace provides *us* upon *your* request of cancellation to the Marketplace, or if *you* enrolled directly with *us*, the date *we* receive a request from *you* to terminate this *policy*, or any later date stated in *your* request; or
4. The date *we* decline to renew this *policy*, as stated in the Discontinuance provision; or
5. The date of a *covered person's* death; or
6. The date a *covered person's* eligibility for insurance under this *policy* ceases due to losing *network* access as the result of a permanent move.

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.

For Dependent Members

A *dependent* will cease to be a *covered person* at the end of the premium period in which the *covered person* ceases to be *your dependent* due to divorce or if a child ceases to be an *eligible child*. For *eligible children*, the Marketplace will send a termination letter with an *effective date* the last day of the *dependent's* 26th birth month.

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

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

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

The policyholder must provide notification and proof of the incapacity or dependency to *us* at *our* request and expense.

There is no time limit for the policyholder to provide notification that their incapacitated *dependent* has reached the age limit.

Open Enrollment

There will be an open enrollment period for coverage on the 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 Enrollment Periods

In general, a *qualified individual* has 60 days to report certain life changes, known as "qualifying events" to the Health Insurance Marketplace or by using Ambetter's *Enhanced Direct Enrollment* tool. *Qualified Individuals* may be granted a Special Enrollment Period where they may enroll in or

change to a different Marketplace plan during the current plan year if they have a qualifying event. Qualifying events include:

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

14. A *qualified individual* newly gains access to an employer sponsored Individual Coverage Health Reimbursement Arrangement (ICHRA) (as defined in 45 CFR 146.123(b)) or a Qualified Small Employer Health Reimbursement Arrangement (QSHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code);
15. At the option of the Health Insurance Marketplace, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a plan through the Health Insurance Marketplace following termination of enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence; or
16. A *qualified individual* or *dependent* is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions or government subsidies completely cease.

To determine if *you* are eligible and apply for a Special Enrollment Period, ***please visit Healthcare.gov 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 of Oklahoma, please contact Member Services at 1-833-492-0679 with any questions related to *your* health insurance coverage

Coverage Effective Dates for Special Enrollment Periods

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

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

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

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

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

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

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:

Premium payments are due in advance, on a calendar month basis. Monthly payments are due before the first day of each month for coverage effective during such month. After the first premium is paid, a 90 day grace period starting from the premium due date is given for the payment of premium. 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. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if *advanced premium tax credits* are received.

We will continue to pay all appropriate claims for covered services rendered to the member during the first month of the grace period, and may pend claims for covered services rendered to the member in the second and third month of the grace period. We will notify HHS of the non-payment of premiums, the member, as well as providers of the possibility of denied claims when the member is in the second and third month of the grace period. We will continue to collect advanced premium tax credits on behalf of the member from the Department of the Treasury, and will return the advanced premium tax credits on behalf of the member for the second and third month of the grace period if the member exhausts their grace period as described above. 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 before the first day of each month for coverage effective during such month. After the first premium is paid, a 60 day grace period starting from the premium due date is given for the payment of premium. 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. Coverage will remain in force during the grace period; however, claims may pend for *covered services* rendered to the *member* during the grace period. *We will notify HHS, as necessary, of the non-payment of premiums, the member, as well as providers of the possibility of denied claims when the member is in the grace period.*

Third Party Payment of Premiums or Cost Sharing

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

1. Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
2. Indian tribes, tribal organizations or urban Indian organizations;
3. State and Federal Government programs;
4. Family members;
5. An employer for an employee under an ICHRA or QSEHRA plan; or

6. Private, not-for-profit foundations which have no incentive for financial gain, no financial relationship, or affiliation with providers of covered services and supplies on behalf of members, where eligibility is determined based on defined criteria without regard to health status and where payments are made in advance for a coverage period from the effective date of eligibility through the remainder of the calendar year.

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

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

Misstatement of Age

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

Change or Misstatement of Residence

If *you* change *your residence*, *you* must notify the 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 Use

The answer to the tobacco or nicotine question on the application is material to *our* correct underwriting. If a *covered person's use of tobacco or nicotine* has been misstated on the *covered person's* application for coverage under this *policy*, *we* have the right to re-rate 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 medical and *behavioral health covered expenses* require *prior authorization*. In general, *network providers* must obtain *authorization* from us prior to providing a service or supply to a *covered person*. However, there are some *network eligible 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. Receives a service or supply; or
2. Are admitted into a facility.

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

1. At least 5 days prior to an elective admission as an *inpatient* in a *hospital*, 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 *inpatient* admission, including emergent *inpatient* admission.
5. At least 5 days prior to the start of *home health care* except *members* needing *home health care* after *hospital discharge*.

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

1. For 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 1 business day of receipt of all information, but no later than 72 hours from date of receipt of request.
4. For non-urgent pre-service reviews, within 2 business days of receipt of all information, but no later 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 *covered person*.

Failure to Obtain Prior Authorization

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

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

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

Prior Authorization Does Not Guarantee Benefits

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

Denial of Prior Authorization

Refer to the Grievance and Complaint 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. 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.

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

When you, or a covered *dependent*, receive health care services from a provider, there may be multiple claims for that episode of care. An episode of care means the services provided by a health care facility or provider to treat a condition or an *illness*. Each claim that we receive for services covered under this *policy* 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 meeting 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)* due for a *covered service* or supply. *Coinsurance* amounts do not apply toward the *deductible* but do apply toward your *maximum out-of-pocket* amount. When the annual *out-of-pocket maximum* has been met, additional *covered services* will be 100%.

Deductible

The *deductible amount* means the amount of *eligible service expenses* that must be paid by all *covered persons* before any benefits are payable. The *deductible amount* does not include any *copayment amount* or *coinsurance* amount. Not all *eligible 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 payable will be subject to:

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

3. Any reduction for expenses incurred at a *non-network provider*. Please refer to the information on the *Schedule of Benefits*.

The applicable *deductible amount(s)*, *coinsurance* 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 *coinsurance* 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 provider* for each *member*. If *you* do not select a *network primary care provider* for each *member*, one will be assigned. *You* may select any *network primary care provider* who is accepting new patients from any of the following provider types:

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

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

You may obtain a list of *network primary care providers* at *our* website and using the “find a Provider” function or by calling the telephone number shown on the front page of this *policy*. *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 directives are and file directives appropriately in *your* medical record

Your network primary care provider will be responsible for coordinating all covered health services with other *network providers*.

Changing Your Primary Care Physician (PCP)

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

Contacting Your Primary Care Physician

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

Should *you* need care outside of *your PCP's* office hours, *you* should call *your PCP's* office for information on receiving after hours care in *your* area. If *you* have an urgent medical problem or question or cannot reach *your PCP* during normal office hours, call *our* 24/7 nurse advice line at 1-833-492-0679 (TDD/TTY: 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.

Coverage Under Other Policy Provisions

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

Non-Emergency Services Outside of Service Area

If *you* are traveling outside of the Oklahoma *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 Oklahoma 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. Except for *dependents* living outside of the *service area*, *members* traveling outside of the *service area* will be responsible for ensuring that their *non-network providers* obtain *prior authorization* to be eligible for benefits for any non-emergency health services, including admissions to non-network facilities. *We* apply *our* medical coverage policies to all requests when evaluating the *medical necessity* for *non-network provider* services, which includes considering the absence of or the exhaustion of all *network* resources. Failure to request *prior authorization* will result in denial of coverage.

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 call *us* and report *your emergency* within one business day. *You* do not need *prior authorization* for *emergency* care services.

Continuity of Care

Under the No Surprises Act, if a *member* is receiving a *covered service* with respect to a *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*. Ambetter will provide access to *third party* services at preferred or discounted rate. The preferred or discounted rates to these services may be communicated to all *members* by email, mail or phone promotions. The preferred partnerships are optional benefits to all *members*.

MAJOR MEDICAL EXPENSE BENEFITS

This *policy* provides coverage for healthcare services for *members* and *dependents*. Some services require *prior authorization*. *Copayment, deductibles, and coinsurance amounts* must be paid to your *network provider* or *non-network provider* at the time services are rendered. *Covered services* are subject to all *policy* provisions, including conditions, terms, limitations and exclusions. *Covered services* must be *medically necessary* and not *experimental or investigational*.

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

Ambulance Service Benefits

Covered expenses will include ambulance services for local ground transportation, transportation from home, scene of accident, or medical *emergency*:

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

Benefits for air ambulance services are limited to:

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

Prior authorization is not required for *emergency* ambulance transportation. Note: non-emergency ambulance transportation requires *prior authorization*. Unless otherwise required by federal or state law, if *you* receive services from non-network ambulance providers, *you* may be responsible for costs above the allowed charges.

Exclusions:

No benefits will be paid for:

1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law;
2. Non-emergency air ambulance;
3. Ambulance services provided for a *member's* comfort or convenience; or
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 neonatal special care unit for newborn infants for treatment of *illnesses, injuries, congenital birth defects*, or complications of premature birth that require that level of care.

3. Transportation between *hospitals* or between a *hospital* and a skilled nursing, *rehabilitation facility* and *member's* home when authorized by Ambetter of Oklahoma.
4. When ordered by an employer, school, fire or public safety official and the *member* is not in a position to refuse; or
5. When a *member* is required by *us* to move from a *non-network provider* to a *network provider*.

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

Limitations: 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.

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

Exclusions:

No benefits will be paid for:

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

Autism Spectrum Disorder Benefits

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

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

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

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

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*, *deductible amount* and *cost sharing* percentage provisions.

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.

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 insureds who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

"Clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, funded or approved by:

- 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;
- A cooperative group or center of any of the entities listed above or the Department of Defense or the Department of Veteran Affairs;
- 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;
The study or investigation is a drug trial that is exempt from having such an *investigational* new drug application; 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. A *qualified individual* must be eligible to participate in the clinical trial, and either (a) have a referral from a doctor stating that the clinical trial would be

appropriate based upon the individual having cancer or a life-threatening disease or condition; or (b) the individual must provide medical and scientific information establishing that their participation in the clinical trial would be appropriate based on the individual having cancer or a life-threatening disease or condition.

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. Such documents shall be made available to Ambetter of Oklahoma upon request.

Colorectal Cancer Examinations and Laboratory Tests

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

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

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

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. Intrauterine devices (IUD), including insertion and removal;
2. Barrier methods including: male and female condoms (Rx required from provider, limited to 30 per month), diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide and spermicide alone;
3. Oral contraceptives including the pill (combined pill and extended/continuous use), and the mini pill (Progestin only), patch;
4. Other hormonal contraceptives, including inserted and implanted contraceptive devices, hormone contraceptive injections and the vaginal contraceptive ring;
5. *Emergency* contraception (the morning after pill);
6. Prescription based sterilization procedures for women; and
7. FDA-approved tubal ligation.

Diabetic Care

For *medically necessary* services and supplies used in the treatment of diabetes. *Covered expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine or ketone strips, blood glucose monitor supplies, glucose strips for the device, and syringes or

needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication; and one retinopathy examination screening per year. Any additional diabetes equipment, related supplies and health care provider services that are *medically necessary* for the treatment of diabetes as determined on an annual basis by The State Board of Health as being *medically necessary* for the treatment of diabetes will also be *covered expenses*, subject to the terms of this *policy* and provided any equipment and supplies have been approved by the federal Food and Drug Administration (FDA).

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. *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.

Insulin: The total amount *you* will be required to pay for a covered insulin medication will not exceed \$30 per 30-day supply or \$90 per 90-day supply. If *your* cost share per 30-day supply of insulin medication is less than \$30 or 90-day supply of insulin medication is less than \$90, *you* will be responsible for the lower amount. Please refer to *our* formulary for tier placement of insulin medications and *your Schedule of Benefits* for *your cost share* responsibility for the associated drug tier.

Durable Medical Equipment (DME), Prosthetics, and Orthotic Devices

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

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

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

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

Benefits for repairs and replacement do not include the following:

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

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

Durable medical equipment

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

Covered services 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.

Medical and surgical supplies

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

Covered services may include, but are not limited to:

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

Exclusions:

Non Covered Services include but are not limited to:

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

Prosthetics

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

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

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

Covered services may include, but are not limited to:

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

considered contact lenses, and are not considered the first lens following *surgery*. If the *injury* is to one eye or if cataracts are removed from only one eye and the *member* selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.

6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (the first one following cancer treatment, 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).

Orthotic devices

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

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

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

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

Exclusions:

Non-covered services include but are not limited to:

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

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.

Habilitation Expense Benefits

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

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

Habilitative 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, identifying letters, numbers, shapes, etc., appropriate play skills and coping mechanisms.

Home Health Care Service Expense Benefits

Covered expenses 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 are limited to the following charges:

1. *Home health aide services* only if provided in conjunction with skilled registered nurse or licensed practical nursing services.
2. Skilled services of a registered nurse or licensed practical nurse rendered on an outpatient basis.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care*. Please refer to *your Schedule of Benefits* for any limits associated with this benefit.
4. I.V. medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental of *medically necessary durable medical equipment* at the discretion of the plan.
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 *custodial care*, or educational care, under the Home Health Care Service Expense Benefit.

Hospice Care Service Expense Benefits

Hospice care benefits are allowable for a *terminally ill covered person* receiving *medically necessary* care under a *hospice* care program.

The list of *covered expenses* in the Medical and Surgical Expense Benefits provision is expanded to include:

1. Room and board in a *hospice* while the *covered person* 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 *covered person* 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 *covered person* regarding the *covered person's terminal illness*;
7. *Terminal illness counseling* of members of the *covered person's immediate family*; and
8. *Bereavement counseling*.

Exclusions and Limitations:

Any exclusion or limitation contained in the *policy* regarding:

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

Hospital Benefits

Covered 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.

Infertility

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

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

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

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

Mammography Screening

Covered expenses for a *covered person* shall be paid at the following frequency schedule: Age 35 through 39, one baseline mammogram; Age 40 and older, one mammogram every year. Mammograms without regard to age are covered, upon recommendation from a *physician*, when there is a prior history of breast cancer, family history of breast cancer, positive genetic testing or other risk factors. Low-dose mammography screening for the presence of occult breast cancer is not subject to *cost-sharing*.

Maternity Care

Coverage for maternity care: 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 *deductible*, or *coinsurance*. An *inpatient* stay is covered for at least forty-eight (48) hours following a vaginal delivery, and for at least ninety-six (96) hours following a cesarean delivery. We do not require a *physician* or other *healthcare provider* to obtain *prior authorization* for delivery. An *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require notification to the health plan.

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

1. Outpatient and *inpatient* pre- and post-partum care, including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment and childbirth classes;
2. *Physician* home visits and office services;
3. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests;
4. *Complications of pregnancy*;
5. *Hospital* stays for other *medically necessary* reasons associated with maternity care; and
6. Home births performed by a licensed/certified midwife or healthcare professional.

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 Oklahoma, Member Services, 14000 Quail Springs Parkway, Suite 650, Oklahoma City, OK 73134. 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 expenses for *hospital* confinement in connection with childbirth are otherwise included as *covered expenses*, we will not limit the number of days for these expenses to less than that stated in this provision.

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery or less than ninety-six (96) hours following a delivery by cesarean section. However, we may provide benefits for *covered 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. In any case, issuers may not, under federal law, require that a provider obtain *prior authorization* from the issuer for prescribing a length of stay not in excess of 48 hours or 96 hours.

The level of benefits and out-of-pocket costs for any later part of the 48-hour or 96-hour stay will not be less favorable to the mother or newborn than any earlier part of the stay. We do not require that a *physician* or other *healthcare provider* obtain *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 *surrogates* and children born from *surrogates*. Please refer to General Non-Covered Services and Exclusions as limitations may exist.

Medical Foods and Nutritional Services

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.

We also cover nutritional services for the treatment of cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, or kidney disease up to a maximum of six visits per year per condition. Benefits for medical foods are exempt from any *deductible* requirements.

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

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 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 a part of a treatment plan that was prescribed by a *physician*.
 - c. *Injury* to the natural teeth will not include any *injury* as a result of chewing;
- 12. For reconstructive breast *surgery* charges as a result of a partial or total mastectomy. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas;
- 13. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the *Schedule of Benefits* for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *policy*, including the *deductible amount* and *percentage* provisions;
- 14. For the following types of tissue transplants:
 - a. Cornea transplants;
 - b. Artery or vein grafts;
 - c. Heart valve grafts;
 - d. Prosthetic tissue replacement, including joint replacements; and
 - e. Implantable prosthetic lenses, in connection with cataracts;
- 15. Family Planning for certain professional provider contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.
- 16. Cochlear implants and bone anchored hearing aids;
- 17. Audiological services and hearing aids (limited to one per ear each four year period);
- 18. *Medically necessary services* made by a *physician* who renders services in an in-network *urgent care center*, including facility costs and supplies;
- 19. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging.
- 20. Allergy testing;
- 21. *Medically necessary telehealth services* subject to the same clinical and *utilization review* criteria, plan requirements and limitations as the same health care services when delivered to an insured in person. *Telehealth Services* provided by *Ambetter Telehealth* are subject to \$0 *copay*. *Telehealth Services* not provided by *Ambetter Telehealth* would be subject to the same *cost sharing* as the same health care services when delivered to an insured in-person. Pursuant to federal regulation, the \$0 cost share does not apply to *members* enrolled in an HSA-eligible plan. Please review *your Schedule of Benefits* to determine if *your* plan is HSA-eligible.
- 22. For *medically necessary* genetic blood tests;
- 23. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV);
- 24. For *medically necessary* biofeedback services.
- 25. For *medically necessary* allergy treatment.
- 26. Therapeutic abortion performed to save the life or health of the *member*, or as a result of incest or rape.
- 27. Coverage for *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis for qualified individuals.

Mental Health and Substance Use Disorder Benefits

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

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

Deductible amounts, copayment or coinsurance amounts and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

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

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

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

Inpatient

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

Outpatient

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

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

We oversee the delivery and oversight of covered *behavioral health* and *substance use disorder* services for Ambetter of Oklahoma. If you need mental health or *substance use disorder* treatment, you may choose any provider participating in *our behavioral health* and *substance use provider network* and do not need a

referral from *your PCP* in order to initiate treatment. *You* can search for in-network *Behavioral Health providers* by using *our* Find a Provider tool at ambetterofoklahoma.com or by calling Member Services at 1-833-492-0679 (TDD/TTY: 711). *Deductible amounts, copayment, or coinsurance amounts* and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health services benefits.

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

In addition, integrated *care management* is available for all of *your* healthcare needs, *including behavioral health* and *substance use*. Please call 1-833-492-0679 (TDD/TTY: 711) to be referred to a care manager for an assessment.

Other Dental Services

Anesthesia and *hospital* charges for dental care, for a *member* less than 19 years of age or a *member* who is physically or mentally disabled, are covered if the *member* requires dental treatment to be given in a *hospital* or outpatient ambulatory surgical facility. The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the *member's* condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Outpatient Medical Supplies Expense Benefits

Covered expenses for outpatient medical supplies are limited to charges:

1. For artificial eyes and polishing of such, for larynx, breast prosthesis, or basic artificial limbs but not the replacement thereof, unless required by a physical change in the *covered person* and the item cannot be modified. If more than one *prosthetic device* can meet a *covered person's* functional needs, only the charge for the most cost effective *prosthetic device* will be considered a *covered expense*. Coverage provided for eligible charges shall be no less than eighty (80%) of Medicare allowable as defined by the Centers for Medicare & Medicaid Services, Healthcare Common Procedure Coding System;
2. For one pair of foot orthotics per *covered person*;
3. For rental of *medically necessary durable medical equipment*;
4. For the rental of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint *surgery*;
5. For a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic *injury* or corneal disease, infectious or non-infectious, and (2) For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract *surgery*. See the *Schedule of Benefits* for benefit levels or additional limits; and
6. For the cost of a monofocal lens, if the multifocal lens is implanted after a cataract extraction.

Pediatric Vision Benefits – Children under the age of 19

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

1. Routine ophthalmological exam
 - a. Refraction;
 - b. Dilation;
 - c. Contact lens fitting.

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

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

Services not covered:

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

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

1. A *prescription drug*.
2. Prescribed, self-administered anticancer medication. Note: Coverage is provided in accordance with Oklahoma state law and prescribed orally administered anticancer medications is covered no less favorably than intravenously administered or injected cancer medications.
3. Contraceptive devices prescribed by a *physician*.
4. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician*.
5. 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.

Covered expenses shall include coverage for prescribed drugs or devices approved by the United States Food and Drug Administration for use as a contraceptive.

The appropriate drug choice for a *covered person* is a determination that is best made by the *covered person* and the *covered person's physician*.

Drug Synchronization

Covered expenses includes the *synchronization* of *prescription drug* refills on at least one occasion per insured per year, provided all of the following conditions are met:

1. The *prescription drugs* have been approved by a formulary exceptions process;
2. The *prescription drugs* are maintenance medications and have available refill quantities at the time of *synchronization*;
3. The medications are not Schedule II, III or IV controlled substances;
4. The insured meets all utilization management criteria to the *prescription drugs* at the time of *synchronization*;
5. The *prescription drugs* are of a formulation that can be safely split into short-fill periods to achieve *synchronization*;
6. The *prescription drugs* do not have special handling or sourcing needs as determined by the plan, contract, or agreement that require a single, designated pharmacy to fill or refill the prescription; and
7. The *covered person* agrees to the *synchronization*

Certain specialty and non-specialty generic medications may be covered at a higher *cost share* than other generic products. Please reference the formulary and *Schedule of Benefits* for additional information. For purposes of this section the tier status as indicated by the formulary will be applicable.

Notice and Proof of Loss:

In order to obtain payment for *covered expenses* incurred at a *pharmacy* for *prescription orders*, a notice of claim and *proof of loss* must be submitted directly to us.

Lock-in Program:

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

Exclusions and Limitations:

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

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance, unless listed on the formulary;
2. For immunization agents otherwise not required under the Affordable Care Act;
3. For medication that is to be taken by the *covered person*, in whole or in part, at the place where it is dispensed;
4. For medication received while the *covered person* is a patient at an institution that has a facility for dispensing pharmaceuticals;
5. For a refill dispensed more than 12 months from the date of a *physician's* order;
6. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs;
7. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary. This exclusion does not apply to prescribed FDA approved contraceptive methods;
8. For drugs labeled "Caution - limited by federal law to *investigational* use" or for *investigational* or *experimental* drugs;
9. For more than a 30-day supply when dispensed in any one prescription or refill, or for some maintenance drugs up to a 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply *network*. Specialty drugs and other select drug categories are limited to 30-day supply when dispensed by retail or mail order. Please note that only the 90 day supply is subject to the discounted *cost sharing*. Mail orders less than 90 days are subject to the standard *cost sharing* amount;
10. For *prescription drugs* for any *covered person* who enrolls in Medicare Part D as of the date of the *covered person's* enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date;
11. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program;
12. Drugs or dosage amounts determined by Ambetter to be ineffective, unproven or unsafe for the indication for which they have been prescribed, regardless of whether the drugs or dosage amounts have been approved by any governmental regulatory body for that use;
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 section if obtained in the United States;
14. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations;
15. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventative treatment is related to *member's* vacation for out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases;
16. Medications used for cosmetic purposes;
17. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary;
18. For any drug dispensed from a non-lock-in pharmacy while *member* is in a lock-in program.
19. For infertility drugs unless otherwise listed on the formulary;
20. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office;
21. For any drug related to *surrogate pregnancy*;
22. For any injectable medication or biological product that is not expected to be self-administered by the *member* at the *member's* place of *residence* unless listed on the formulary; and
23. Medication refills where a *member* has more than 15 days' supply of medication on hand.

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

Prescriptions 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 ambetterofoklahoma.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 ambetterofoklahoma.com. You can also request to have a copy mailed directly to *you*.

Split-Fill Dispensing Program

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

Medication Balance-On-Hand

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

Mail Order Pharmacy

If *you* have more than one prescription *you* take regularly, *you* may select to enroll in *our* mail order delivery program. Your prescriptions will be safely delivered right to *your* door at no extra charge to *you*. You will still be responsible for *your* regular *copayment/coinsurance*. To enroll for mail order delivery or for any additional questions, call *our* mail order pharmacy at 1-888-624-1139. 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.”

Formulary or Prescription Drug List

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

Please note, the formulary is not meant to be a complete list of the drugs covered under *your* prescription benefit. Not all dosage forms or strengths of a drug may be covered. This list is periodically reviewed and

updated and may be subject to change. Drugs may be added or removed or additional requirements may be added in order to approve continued usage of a specific drug.

For the most current Ambetter Formulary or Prescription Drug List or for more information about *our* pharmacy program visit ambetterofoklahoma.com (under “for Member”, “Pharmacy Resources”) or call Member Services at 1-833-492-0679 (TDD/TTY: 711).

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.

Certain specialty and non-specialty generic medications may be covered at a higher *cost share* than other generic products. Please reference the formulary and *Schedule of Benefits* for additional information. For purposes of this section the tier status as indicated by the formulary will be applicable.

Prescription Drug Exception Process

Standard exception request

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

Expedited exception request

A *member*, a *member’s* designee or a *member’s* prescribing *physician* may request an expedited review based on exigent circumstances. Exigent circumstances exist when a *member* is suffering from a health condition that may 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 expedited exception request be granted, *we* will provide coverage of the non-formulary drug for the duration of the exigency.

External exception request review

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

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

Preventive Care Expense Benefits

Covered expenses are expanded to include the charges incurred by a *covered person* for the following preventive health services if appropriate for that *covered person* 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;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual;
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration;
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women;
5. Complications resulting from the smallpox vaccine;
6. BRCA genetic cancer testing for women with a family history of certain cancers;
7. Covers without *cost sharing*:
 - a. Screening for *tobacco or nicotine use*; and
 - b. For those who use nicotine or tobacco products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
 - i. Four (4) nicotine or tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without *prior authorization*; and
 - ii. All Food and Drug Administration (FDA) approved nicotine or tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a *healthcare provider* without *prior authorization*; and
8. Preventive bone density testing is covered as follows:
 - a. Screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.
 - b. Screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older.

Benefits when billed as a preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any *deductibles* or *coinsurance* provisions, and *copayment amounts* under the *policy* when the services are provided by a *network provider*. Whether something is preventive is determined by the claim service data submitted by the provider.

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

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

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

Prostate Specific Antigen Testing

Covered expenses include an annual digital rectal examination and "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for a *covered person* who is at least fifty (50) years of age; and at least once annually for a *covered person* who is at least forty (40) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Radiology, Imaging and Other Diagnostic Testing

Medically necessary radiology services, imaging and tests performed for diagnostic reasons are a covered benefit (e.g., X-ray, MRI, CT scan, PET/SPECT, mammogram, and ultrasound). *Prior authorization* may be required, see the *Schedule of Benefits* for details. Note: Depending on the service performed, two bills may be incurred – both subject to any applicable *cost sharing* – one for the technical component (the procedure itself) and another for the professional component (the reading/interpretation of the results by a *physician* or other qualified practitioner).

Rehabilitation and Extended Care Facility Expense Benefits

Covered 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*.

Second Medical Opinion

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

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

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

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

Skilled Nursing Facility Expense Benefits

Covered expenses include expenses incurred for services or confinement in a *skilled nursing facility*, subject to the following limitations:

1. Services or confinement in a *skilled nursing facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, the same *illness* or *injury* that resulted in the *hospital* stay;
2. *Covered expenses* for *provider facility* services are limited to charges made by a *hospital* or *skilled nursing facility* for:
 - a. Daily room and board and nursing services;
 - b. Diagnostic testing; and
 - c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.

Skilled nursing facility charges are limited to 30 days per *covered person* per year. See the *Schedule of Benefits* for benefit levels or additional limits.

Sleep Studies

Sleep studies are covered when determined to be *medically necessary*; *prior authorization* may be required. Note: A sleep study can be performed either at home or in a facility.

Social Determinants of Health Supplemental Benefits

Social determinants of health supplemental benefits and services may be offered to *members* to remove barriers to accessing health services and improve overall health outcomes. These are benefits and services that *we* may make available in connection with this *policy*. The benefits and services provided may include transportation to health services, assistance with childcare, access to healthy meals, and other relevant services based on need. The benefits are available as long as coverage remains active, unless changed by *us*. Upon termination of coverage, the benefits are no longer available. All *members* are eligible for the benefits upon obtaining coverage. The services are optional, and the benefits are made available at no additional cost to the enrollees. The benefits and services available at any given time are made part of this *policy* 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. *Members* may receive notifications about available benefits and services through emails from local health plans and through the “My Health Pays” notification system. To inquire about these benefits and services or other benefits available, *you* may visit *our* website at ambetterofoklahoma.com or by contacting Member Services at 1-833-492-0679 (TDD/TTY: 711).

Transplant Expense Benefits

Covered expenses for transplant service expenses:

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

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

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

If we determine that a *covered person and donor* are appropriate candidates for a *medically necessary* transplant, live donation, *covered expenses* will be provided for:

1. Pre-transplant evaluation;
2. Pre-transplant harvesting;
3. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant);
4. Outpatient *covered services* related to the transplant *surgery*, pre-transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection, and other immunosuppressive drug therapy, etc.;
5. Pre-transplant stabilization, meaning an *inpatient* stay to *medically stabilize* a *covered person* 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 a participating facility;
7. Post-transplant follow-up visits and treatments;
8. Donor testing if the donor is found compatible;
9. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors; and
10. 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 at www.ambetter.com.

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

Ancillary “Center Of Excellence” Service Benefits:

A *covered person* may obtain services in connection with a *medically necessary* 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 *covered person* 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 *covered person*, any live donor, and the *immediate family* to accompany the *covered person* to and from the *Center of Excellence*, in the United States.
- b. When *covered person* 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 *covered person* while the *covered person* 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 *covered person* 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 *medically necessary* transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision 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 through the *Center of Excellence* and is not included under this provision as a transplant.
7. The acquisition cost for the organ or bone marrow, when provided at an unauthorized facility or not obtained through the *Center of Excellence*.
8. For any transplant services and/or travel related expenses for the enrollee and donor, when performed outside of the United States.
9. 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, 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 service expenses*
- s. Any fuel costs/charging station fees for electric cars.

Organ Transplant Medication Notification

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

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

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

Urgent Care

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

Members are encouraged to contact their *primary care provider* for an appointment before seeking care from another provider, but *network urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *primary care provider* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-833-492-0679 (TDD/TTY: 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 enrollees 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 ambetterofoklahoma.com or by contacting Customer Service by telephone at 1-833-492-0679 (TDD/TTY: 711). The benefits are available as long as coverage remains active, unless changed by *us* as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All enrollees are eligible for program benefits upon obtaining coverage. The programs are optional, and the benefits are made available at no additional cost to the enrollees. The programs and benefits available at any given time are made part of this *policy* by this reference and are subject to change by *us* through updates available on *our* website or by contacting *us*.

Care Management Programs

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

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

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

If *you* think *you* could benefit from *our care management* program, please call Member Services at 1-833-492-0679 (TDD/TTY: 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 *you* or *your* covered *dependent* in the absence of insurance covering the charge.
2. Expenses, fees, taxes or surcharges imposed on *you* or *your* covered *dependent* by a provider, including a *hospital*, but that are actually the responsibility of the provider to pay.
3. Any services performed for a *member* by a *covered person's immediate family*.
4. Any services not identified and included as *covered expenses* under the *policy*. *You* will be fully responsible for payment for any services that are not *covered 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 provider; and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness*, or covered under the Preventive Care Expense Benefits provision.

Covered 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*.
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.
4. For the reversal of sterilization and the reversal of vasectomies.
5. For an elective *abortion* for any reason other than:
 - a. To prevent the death of the mother upon whom the *abortion* is performed. However, an *abortion* shall not be deemed an elective *abortion* to prevent the death of the mother based on a claim or diagnosis that without the *abortion* the mother will engage in conduct that will result in the mother's death; or
 - b. In a *pregnancy* resulting from rape or incest.
6. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered expenses* of the Major Medical Expense Benefits provision;
7. For expenses for television, telephone, or expenses for other persons;
8. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
9. For telephone consultations, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment;
10. For stand-by availability of a *medical practitioner* when no treatment is rendered;
11. For *dental service* expenses, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits;
12. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect in a child who has been a *covered person* from its birth until the date *surgery* is performed;
13. For mental health exams and services involving:
 - 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 maintaining employment. Benefits will be allowed for services that would otherwise be covered under this *policy*.
14. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Expense Benefits;
 15. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism;
 16. While confined primarily to receive *rehabilitation, custodial care*, educational care, or nursing services, unless expressly provided for by the *policy*;
 17. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*;
 18. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs;
 19. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the *policy*;
 20. 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;
 21. For hearing aids, except as expressly provided in this *policy*.
 22. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of ninety (90) consecutive days;
 23. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *covered person* 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 *covered person'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 *covered person's* workers' compensation claim, this exclusion will still apply unless that denial is *appealed* to the proper governmental agency and the denial is upheld by that agency;
 24. *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*.
 - k. 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.
25. For fetal reduction *surgery*;
 26. Except as specifically identified as a *covered expense* under the *policy*, 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;
 27. 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 *covered person* is paid to participate or to instruct; racing or speed testing any non-motorized vehicle or conveyance, if the *covered person* is paid to participate or to instruct; rodeo sports; horseback riding, if the *covered person* is paid to participate or to instruct; rock or mountain climbing, if the *covered person* is paid to participate or to instruct; or skiing, if the *covered person* is paid to participate or to instruct;
 28. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *covered person* 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;
 29. For *prescription drugs* for any *covered person* who enrolls in Medicare Part D as of the date of the *covered person's* enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date;
 30. For the following miscellaneous items: artificial insemination (except where required by federal or state law); biofeedback; care or complications resulting from non-covered expenses; chelating agents; domiciliary care; food and food supplements; routine foot care, foot orthotics, corrective shoes, or orthopedic shoes that are not attached to an appliance; 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*;
 31. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment. Benefits will be allowed for services that would otherwise be covered under this *policy*;
 32. For any medicinal and recreational use of cannabis or marijuana;
 33. For any non-medically necessary court ordered care for a medical/surgical or mental health/substance use disorder diagnosis, unless required by state law;
 34. Expenses for services related to immunizations for travel and occupational purposes;
 35. Expenses for services related to *respite care*;
 36. Expenses for services related to massage therapist;
 37. Expenses for services related to naprapatic services; and
 38. Expenses for services related to naturopathic services.

TERMINATION

Termination of Policy

All insurance will cease on termination of this *policy*. This *policy* will terminate on the earliest of:

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

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 Marketplace, or if an off-exchange *member* by written notice, delivered or mailed to *us*. Such cancellation shall become effective upon receipt, or on such later date specified in the notice. If *you* cancel, *we* shall promptly return any unearned portion of the premium paid, but in any event shall return the unearned portion of the premium within 30 days. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the *effective date* of the cancellation.

Reinstatement

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

If *you* enrolled through the Marketplace and *your* benefits were terminated because *you* did not pay *your* premium in full by the end of *your* grace period, *you* will not be able to reinstate *your* benefits.

If *you* did not enroll through the Marketplace and if any renewal premium is not paid within the time granted for payment, a subsequent acceptance of premium by *us*, which is not part of a new application, shall reinstate benefits under this *policy*. However, if *we* require an application for reinstatement and issue a conditional receipt for the premium tendered, benefits under the *policy* will be reinstated upon approval of the application by *us*. If *we* do not provide *you* with an approval or disapproval within forty-five days of issuing the conditional receipt, then the *policy* will be reinstated. The reinstated *policy* shall cover only loss resulting from accidental *injury* sustained after the date of reinstatement and loss due to sickness that may begin ten (10) days after such date. In all other respects, *you* shall have the same rights as *you* had under the *policy* immediately before the due date of the defaulted premium, subject to any provisions endorsed or attached in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

Discontinuance

90-Day Notice: If *we* discontinue offering and decide not to renew all policies 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 ninety (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/certificates 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 one hundred eighty (180) days prior to the date that *we* stop offering and terminate all existing individual policies in the individual market in the state where *you* reside.

RIGHT OF REIMBURSEMENT

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

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

If this plan provides benefits under this *policy* to a *covered person* for expenses incurred due to *third party injuries*, then the plan retains the right to repayment of the full cost of all benefits provided by this plan on behalf of the *covered person* that are associated with the *third party injuries*. The plan's rights of recovery apply to any recoveries made by or on behalf of the *covered person* from any source, 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 *covered person* for *third party injuries*.

By accepting benefits under this plan, the *covered person* specifically acknowledges Ambetter of Oklahoma's right to subrogation. When this plan provides health care benefits for expenses incurred due to *third party injuries*, Ambetter of Oklahoma shall be subrogated to the *covered person's* rights of recovery against any party to the extent of the full cost of all benefits provided by this plan. Ambetter of Oklahoma may proceed against any party with or without the *covered person's* consent.

By accepting benefits under this plan, the *covered person* also specifically acknowledges Ambetter of Oklahoma's 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 *covered person* or the *covered person's* representative has recovered any amounts from any source. By providing any benefit under this plan, Ambetter of Oklahoma is granted an assignment of the proceeds of any settlement, judgment or other payment received by *you* to the extent of the full cost of all benefits provided by this plan. Ambetter of Oklahoma's right of reimbursement is cumulative with and not exclusive of Ambetter of Oklahoma's subrogation right and Ambetter of Oklahoma may choose to exercise either or both rights of recovery.

As a condition for *our* payment, the *covered person* or anyone acting on the *covered person's* 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 *covered person* in connection with the *loss*;
3. To include the amount of benefits paid by *us* on behalf of a *covered person* in any claim made against any *third party*;
4. To give Ambetter of Oklahoma 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 Ambetter of Oklahoma 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 *covered person* in connection with the *loss* equal to the amount *we* have 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 subrogated to all of the rights of the *covered person* against any *third party* to the extent of the benefits paid on the *covered person's* behalf; and
 - e. May assert that subrogation right independently of the *covered person*;
7. To take no action that prejudices *our* reimbursement and subrogation rights, including, but 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 and subrogation 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; and
11. That *we* may reduce other benefits under the *policy* by the amounts a *covered person* has agreed to reimburse *us*.

Our right of subrogation and reimbursement only exists to the extent the *covered person* has been made whole. Any costs associated with subrogation shall be shared in the same proportion as each participant shared in the recovery amount.

COORDINATION OF BENEFITS

We coordinate benefits with other payers when a *member* is covered by two or more health benefit plans. Coordination of Benefits (COB) is the industry standard practice used to share the cost of care between two or more carriers when a *member* is covered by more than one health benefit plan.

It is a contractual provision of a majority of health benefit contracts. We comply with federal and state regulations for COB and follows COB guidelines published by National Association of Insurance Commissioners (NAIC).

Under COB, the benefits of one plan are determined to be primary and are first applied to the cost of care. After considering what has been covered by the primary plan, the secondary plan may cover the cost of care up to the fully allowed expense according to the plan's payment guidelines. Our Claims COB and Recovery Unit procedures are designed to avoid payment in excess of allowable expense while also making sure claims are processed both accurately and timely.

"Allowable expense" is the necessary, reasonable, and customary item of expense for healthcare, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid. When Medicare is the primary plan, Medicare's allowable expense is the allowable expense when we are paying claims as the secondary plan.

1. If a plan is advised by a *covered person* that all plans covering the person are high-*deductible* health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-*deductible* health plan's *deductible* is not an allowable expense, except for any health care expense incurred that may not be subject to the *deductible* as described in Section 223 (c)(2)(C) of the Internal Revenue Code of 1986.
2. An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.
3. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a *covered person* is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

- a) 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 *hospital* room expenses.
- b) If a person is covered by two (2) 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.
- c) If a person is covered by two (2) 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) 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. However, if the provider has contracted with the secondary plan to provide the benefits or services for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

The term “Plan” includes:

1. Group and non-group insurance contracts and subscriber contracts;
2. Uninsured arrangements of group or group-type coverage;
3. Group and non-group coverage through closed panel plans;
4. Group-type contracts;
5. The medical care components of long-term care contracts, such as skilled nursing care;
6. The medical benefits coverage in automobile “no fault” and traditional automobile “fault” type contract; and
7. Medicare or other governmental benefits, as permitted by law.

The term “Plan” does not include:

1. Hospital indemnity coverage benefits or other fixed indemnity coverage;
2. Accident only coverage;
3. Specified disease or specified accident coverage;
4. Limited benefit health coverage;
5. School accident-type coverages that cover students for accident only, including athletic *injuries*, wither on a twenty-four hour basis or on a “to and from school” basis;
6. Benefits provided in long-term care insurance policies of non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, *respite care*, and *custodial care* or for contracts that pay a fixed daily benefits without regard to expense incurred or the receipt of services;
7. Medicare supplement policies;
8. A state plan under Medicaid; or
9. A governmental plan, which by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

“Primary plan” is one whose benefits must be determined without taking the existence of any *other plan* into consideration. A plan is primary if either:

1. the plan has no order of benefits rules or its rules differ from those required by regulation; or
2. all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

“Secondary plan” is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 1-7 that applies will determine which plan will be primary:

1. The Primary plan pays or provides its benefits as if the Secondary plan or plans did not exist. A Plan may consider benefits paid or provided by another Plan in determining its benefits only when it is secondary to that *other plan*.
2. If the *other plan* does not contain a coordination of benefits provision that is consistent with this provision, that plan is always primary. There are two exceptions:
 - a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, and
 - b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a *covered person* may continue to be excess to such basic benefits.

3. Each plan determines its order of benefits using the first of the following rules that apply:
- a. *Non-Dependent or Dependent.* 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.* 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) If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the *calendar year* (excluding year of birth) shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary.
 - (ii) If a child is covered by both parents' plans, the parents are separated or divorced, whether or not they have ever been married:
 - A. If a court order or decree states that one of the parents is responsible for the *dependent* child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the *dependent* child's health care expenses, but that parent's *spouse* does, that parent's *spouse's* plan is the primary plan. This rule applies to the plan years commencing after the plan is given notice of the court decree;
 - B. If a court order or decree states that both parents are responsible for or orders joint custody without considering for the *dependent* child's health care expenses or health care coverage, the provisions of subparagraph (i) above shall determine the order of benefits.
 - C. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the step-parent's plan will pay second, and the plan of the parent without custody will pay third;
 - D. If there is no court order or decree allocating responsibility for the *dependent* child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - 1) The plan covering the custodial parent;
 - 2) The plan covering the *spouse* of the custodial parent;
 - 3) The plan covering the non-custodial parent; and then
 - 4) 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 the parents of the child, the provisions of subparagraph i or ii above shall determine the order of benefits as if those individuals were the parents of the child.
4. *Active Employee or Retired or Laid-off Employee.* If the person receiving services is covered under one plan as an active employee or *member* (i.e., not laid-off or retired), or as the *spouse* or child of such an active employee, and is also covered under another plan as a laid-off or retired employee, the plan that covers such person as an active employee or *spouse* or child of an active employee will be primary. If the *other plan* does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored. This rule does not apply if the rule 3(a) can determine the order of benefits.

5. COBRA or State Continuation Coverage. 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 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 labeled 3(a) can determine the order of benefits.
6. Longer or Shorter Length of Coverage. 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.
7. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effects of Coordination

When this plan is secondary, *we* may reduce 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, *we* will calculate the benefits *we* would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under this plan that is unpaid by the primary plan. *We* may then reduce *our* 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, *we* shall credit to *our* plan *deductible* any amounts *we* would have credited to the *deductible* in the absence of other health care coverage. Also, the amount *we* pay will not be more than the amount *we* would pay if *we* were primary. When this plan is secondary as a result of one of *our members* being a Medicare beneficiary, see above definition for allowable expense, as *we* will reduce *our* benefits up to Medicare's allowable.

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

Right to Receive and Release Needed Information

Certain fact about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and *other plans*. *We* may get the facts *we* need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and *other plans* covering the person claiming benefits. *We* need not tell or get the consent of, any person to do this.

Right of Recovery

If the amount of the payments made by this plan is more than *we* should have paid under this COB provision, *we* may recover the excess from one or more of the persons *we* have paid or for whom *we* have paid; or any other person or organization that may be responsible for the benefits or services provided for the *covered person*. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services. If the *covered services* provided by *us* exceed the total amount of benefits that should have been paid under this section, *we* have the right to recover from one or more of the following:

1. Any person to or from whom such payments were made; or
2. *Member* was non eligible at the time of service; or
3. Insurance companies.

CLAIMS

Notice of Claim

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

Proof of Loss

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

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 ambetterofoklahoma.com under “Member Resources”. Send all the documentation to *us* at the following address:

Ambetter of Oklahoma
Attn.: Claims Department
PO Box 5010
Farmington, MO 63640-5010

Cooperation Provision

Each *covered person*, or other person acting on the *covered person's* 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; and
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 *covered person*, or other person acting on the *covered person's* 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 *covered person*, or other person acting on the *covered person's* 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'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'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*.

Foreign Claims Incurred For Emergency Care

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

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

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

The amount of reimbursement will be based on the following:

- *Member's* benefit plan and *member* eligibility on date of service
- *Member's* responsibility/share of cost based on date of service.
- Currency rate at the time of completed transaction, Foreign Country currency to United States currency.

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

Assignment

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

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

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

Medicaid Reimbursement

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

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

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

Our payment to the state will be limited to the amount payable under this *policy* for the *covered 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 *covered person*, 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 *covered person* 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 sixty (60) days after the required *proof of loss* is given. No suit may be brought more than three years after the date *proof of loss* is required.

GRIEVANCE AND COMPLAINT PROCEDURES

Internal Procedures

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 claimant;
2. Person *authorized* to act on behalf of the claimant. **Note:** Written *authorization* is not required; however, if received, we will accept any written expression of *authorization* without requiring specific form, language, or format;
3. In the event the claimant is unable to give consent: a *spouse*, family member, or the treating provider; or
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given *authorization* to represent the claimant.

Important: *Adverse benefit determinations* that are not *grievances* will follow standard PPACA internal *appeals* processes.

Grievances

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

Claimants should submit all documentation to us at:

Ambetter of Oklahoma
PO Box 10341
Van Nuys, CA 91410
1-833-886-7956

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

Resolution Timeframes

1. *Grievances* regarding quality of care, quality of service, or *reformation* will be resolved within 30 calendar days of receipt. The time period may be extended for an additional 30 calendar days, making the maximum time for the entire *grievance* process 60 calendar days if we provide the *claimant* and the *claimant's authorized representative*, if applicable, written notification of the following within the first 30 calendar days:
 - a. That we have not resolved the *grievance*;
 - b. When our resolution of the *grievance* may be expected; and
 - c. The reason why the additional time is needed.
2. All other *grievances* will be resolved and we will notify the *claimant* in writing with the *appeal* decision within the following timeframes:
 - a. Post-service claim: within 30 calendar days after receipt of the *claimant's* request for internal *appeal*; or

- b. Pre-service claim: within 30 calendar days after receipt of the *claimant's* request for internal appeal.

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

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

Refer to a later section for information regarding internal *expedited grievances*.

Acknowledgement

Within five business days of receipt of a *grievance*, a written acknowledgment to the claimant or the claimant'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.

Right to Appear

The claimant who filed the *grievance*, or the claimant's *authorized representative*, has the right to appear in person before the *grievance* panel to present written or oral information. The grievant may submit written questions to the person or persons responsible for making the determination that resulted in the *grievance*.

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

Grievance Panel

The *grievance* panel will not include the person who made the initial determination and is not the subordinate of the original reviewer. The panel may, however, consult with the initial decision-maker. If the panel consists of at least three persons, the panel may then include no more than one subordinate of the person who made the initial determination.

The *grievance* panel will include:

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

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

Expedited Grievance

An *expedited grievance* may be submitted orally or in writing. All necessary information, including *our* determination on review, will be transmitted between the claimant and *us* by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as the *claimant's* health condition requires but not more than 72 hours after receipt of the *grievance*.

Due to the 72-hour resolution timeframe, the standard requirements for notification, *grievance* panel/right to appear, and acknowledgement do not apply to *expedited grievances*.

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

Written Grievance Response

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

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

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

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

Complaints

Basic elements of a *complaint* include:

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

Complaints received from the State Insurance Department

The commissioner may require *us* to treat and process any *complaint* received by the State Insurance Department by, or on behalf of, a claimant as a *grievance* as appropriate. *We* will process the State Insurance Department *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 claimant except to the extent the claimant has other remedies available under applicable federal or state law. *We* will pay for the costs of the external review performed by the independent reviewer.

You may request an external review from:
Oklahoma Insurance Department
400 N. E. 50th Street
Oklahoma City, Oklahoma 73105
Telephone: (800) 522-0071 or (405) 521-2828

Applicability/Eligibility

The *grievance* 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 review process, the claimant has four months to make a written request to the Insurance Commissioner for external review after the date of receipt of *our* internal response. *You* may request an external review by submitting an External Review Request Form that is available on the Oklahoma Insurance Department's website. Within one (1) business day after the date of receipt of a request for external review, the Insurance Commissioner will send a copy of the request to *us*.

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

External review is available for *grievances* 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 business days (immediately for expedited external review requests) following receipt of the request to conduct a preliminary review of the request to determine whether:
 - a. The individual was a *covered person* at the time the item or service was requested;

- b. The service is a *covered service* under the claimant's health plan but for the plan's *adverse benefit determination* with regard to *medical necessity experimental/investigational*, medical judgment, or *rescission*;
 - c. The claimant has exhausted the internal process; and
 - d. The claimant has provided all of the information required to process an external review.
2. Within one business day (immediately for expedited external review requests) after completion of the preliminary review, we will notify the Insurance Commissioner and the claimant in writing as to whether the request is: (1) complete and eligible for external review; (2) complete but not eligible for external review and the reasons for its ineligibility; or (3) not complete and the additional information needed to make the request complete;
 3. Within one (1) business day of receiving notice that a request is eligible for external review (immediately for expedited external review requests), the Insurance Commissioner will assign an IRO;
 4. Within five business days after the date of assignment of the IRO (or upon receipt of notice of the assignment of an IRO in the case of an expedited external review request), we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO. **Note:** For expedited, after assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method;
 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 benefit determination*;
 6. Upon receipt of any information submitted by the claimant, the IRO must forward the information to us within one business day;
 7. Upon receipt of the information, we may reconsider *our* determination. If we reverse *our adverse benefit determination*, we must provide written notice of the decision to the claimant and the IRO within one business day after making such decision. The external review would be considered terminated;
 8. Within 45 days (72 hours for expedited external reviews) after the date of receipt of the request for an external review by the health plan, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to the claimant and to us. If the notice for an expedited review is not in writing, the IRO must provide written confirmation within 48 hours after the date of providing the notice; and
 9. Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, we will approve the covered benefit that was the subject of the *adverse benefit determination*.

Appeals and Grievances filing and key communication timelines

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard Grievance	N/A	3 business days	30 calendar days	30 calendar days
Grievance Committee	10 calendar days	3 business days	30 calendar days	30 calendar days
Standard Pre-Service Appeal	180 calendar days	3 business days	15 business days	15 calendar days
Expedited Pre-Service Appeal	180 calendar days	N/A	24 hours	N/A
Standard Post-Service Appeal	180 calendar days	3 business days	15 business days	15 calendar days
External Review	4 months	5 business days	45 calendar days	N/A
Expedited External review	4 months	N/A	72 hours	N/A

GENERAL PROVISIONS

Entire Contract

This *policy*, with the application, is 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.

Repayment for Fraud, Misrepresentation or False Information

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

Conformity with State Laws

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

Personal Health Information (PHI)

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

We protect all oral, written, and electronic PHI. *We* follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. *We* are required to notify *you* about these practices every year. This notice describes how *your* medical information may be used and disclosed and how *you* can get access to this information. Please review it carefully. If *you* need more information or would like the complete notice, please visit ambetterofoklahoma.com/privacy-practices or call Member Services at 1-833-492-0679 (TDD/TTY: 711).

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

Language

If *you* don't speak or understand the language in *your* area, *you* have the right to an interpreter. For language assistance, please visit ambetterofoklahoma.com/language-assistance.

[illegible]

Statement of Non-Discrimination

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

Ambetter of Oklahoma:

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

If *you* need these services, contact Ambetter of Oklahoma at 1-833-492-0679 (TDD/TTY: 711).

If *you* believe that Ambetter of Oklahoma has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, *you* can file a *grievance* with: Ambetter of Oklahoma, Attn: Appeals and Grievances, PO Box 10341, Van Nuys, CA 91410, 1-833-492-0679 (TDD/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 of Oklahoma 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>.