



FROM



peach state
health plan.™

2022 Evidence of Coverage



Ambetter.pshpgeorgia.com

Ambetter from Peach State Health Plan

EVIDENCE OF COVERAGE

Home Office: 1100 Circle 75 Parkway, Suite 1100, Atlanta, GA 30339

Individual Member HMO Contract

In this *contract*, the terms "*you*", "*your*" or "*yours*" will refer to the *member* or any dependents enrolled in this *contract*. The terms "*we*," "*our*," or "*us*" will refer to Ambetter from Peach State Health Plan (Ambetter).

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

Annually, *we* must file this product, the cost share and the rates associated with it for approval. Guaranteed renewable means that *your* plan will be renewed into the subsequent year's approved product on the anniversary date unless terminated earlier in accordance with *contract* terms. *You* may keep this *contract* (or the new *contract* *you* are mapped to for the following year) in force by timely payment of the required premiums. In most cases *you* will be moved to a new *contract* each year, however, *we* may decide not to renew the *contract* as of the renewal date if: (1) *we* decide not to renew all *contracts* issued on this form, with a new *contract* at the same metal level with a similar type and level of benefits, to residents of the state where *you* then live; (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *covered services*.

In addition to the above, this guarantee for continuity of coverage shall not prevent *us* from cancelling or non-renewing this *contract* in the following events: (1) non-payment of premium; (2) a *member* fails to pay any *deductible* or *copayment amount* owed to *us* and not the provider of services; (3) a *member* is found to be in material breach of this *contract*; or (4) a change in federal or state law, no longer permits the continued offering of such coverage, such as CMS guidance related to individuals who are Medicare eligible.

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

At least 31 day notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *contract* or a change in a *member's* health. While this *contract* is in force, *we* will not restrict coverage already in force. 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 *contract* 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 CONTRACT

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

Ambetter from Peach State Health Plan

A handwritten signature in black ink, appearing to read "Wade A. Rakes". The signature is stylized with a large, looped initial "W" and a distinct "R".

Wade A. Rakes
Plan President & CEO

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INTRODUCTION

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

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

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

Throughout this *contract* *you* may see references for Ambetter and Ambetter from Peach State Health Plan. Both references are correct, as Ambetter operates under its legal entity, Ambetter of Peach State Health Plan.

How to Contact Us

Ambetter from Peach State Health Plan
1100 Circle 75 Parkway, Suite 1100
Atlanta, Georgia 30339

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST, Monday through Friday

Member Services	1-877-687-1180
TDD/TTY line	1-877-941-9231
Fax	1-877-941-8071
24/7 Nurse Advice Line	1-877-687-1180
Emergency	911

Interpreter Services

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

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

To arrange for interpretation services, please call Member Services at 1-877-687-1180 or for the hearing impaired TDD/TTY 1-877-941-9231.

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

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

You have the right to:

1. Participate with *your provider* and *medical practitioners* in decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or *your* legally *authorized representative*. *You* will be informed of *your* care options.
2. Know who is approving and performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our network* of *providers* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your provider* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from *your primary care provider* about what might be wrong (to the level known), treatment and any known likely results. *Your primary care provider* can tell *you* about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally *authorized* person. *Your provider* will ask for *your* approval for treatment unless there is an *emergency* and *your* life and health are in serious danger.
8. Make recommendations regarding *member's* rights, responsibilities and policies.
9. Voice *complaints* or *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 provider(s)* of the medical consequences.
11. See *your* medical records.
12. Be kept informed of *covered* and non-*covered services*, program changes, how to access services, *primary care provider* assignment, providers, advance directive information, referrals and *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*. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
 14. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, ethnicity, race, gender, sex, sexual orientation, national origin, physical or mental disability, or religion.
 15. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
 16. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
 17. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *primary care provider's* instructions are not followed. *You* should discuss all concerns about treatment with *your primary care provider*. *Your primary care provider* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
 18. Select *your primary care provider* within the *network*. *You* also have the right to change *your primary care provider* or request information on *network providers* close to *your* home or work.
 19. Know the name and job title of people giving *you* care. *You* also have the right to know which *provider* is *your primary care provider*.
 20. An interpreter when *you* do not speak or understand the language of the area.
 21. A second opinion by a *network provider* if *you* want more information about *your* treatment or would like to explore additional treatment options.
 22. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it.
 23. Advance directives are forms *you* can complete to protect *your* rights for medical care. It can help *your primary care provider* and other providers understand *your* wishes about *your* health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
 - a. Living Will
 - b. Healthcare Power of Attorney
 - c. "Do Not Resuscitate" Orders. *Members* also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this entire *contract*.
2. Treat all healthcare professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of *your provider* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* ID card and keep scheduled appointments with *your provider*, and call the *provider's* office during office hours whenever possible if *you* have a delay or cancellation.
6. Know the name of *your* assigned *primary care provider*. *You* should establish a relationship with *your provider*. Please ensure you have selected a *PCP* for your Ambetter plan. *You* may change *your primary care provider* verbally or in writing by contacting *our* Member Services Department.

7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* healthcare professionals and *providers* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* or *your* healthcare professionals and *providers* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* healthcare professionals and *provider*.
11. Tell *your* healthcare professional and *provider* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with *your primary care provider* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any *emergency* room only when *you* think *you* have a medical *emergency*. For all other care, *you* should call *your primary care provider*.
14. Provide all information about any other medical coverage *you* have upon enrollment in this plan. If, at any time, *you* get other medical coverage besides this coverage, *you* must tell the entity with which *you* are enrolled.
15. Pay *your* monthly premium on time and pay all *deductible amounts*, *copayment amounts*, or *cost-sharing percentages* at the time of service.
16. Inform the entity in which *you* enrolled to obtain this policy if *you* have any changes to your name, address, or family *members* covered under this policy within 60 days from the date of the event.

IMPORTANT INFORMATION

Provider Directory

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

At any time, *you* can request a printed copy of the provider directory at no charge by calling Member Services at 1-877-687-1180 (TTY/TDD 1-877-941-9231). In order to obtain benefits, *you* must designate a *network primary care provider* for each *member*. We can assist *you* in choosing 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 1-877-687-1180 (TTY/TDD 1-877-941-9231). We will help *you* make the appointment.

Member ID Card

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

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 1-877-687-1180 (TTY/TDD 1-877-941-9231). We will send *you* another card.

Website

Our website can answer many of *your* frequently asked questions and has resources and features that make it easy to get quality care. *Our* website can be accessed at Ambetter.pshpgeorgia.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* Enrollee ID card.
5. *Member* Rights and Responsibilities.
6. Notice of Privacy.
7. Current events and news.
8. *Our* Formulary or Preferred Drug List.
9. Selecting a *primary care provider*.
10. *Deductible* and *copayment* accumulators.

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

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

Protection from *Balance Billing*

Under Federal law, effective January 1, 2022, *Non-Network Providers* or Facilities in 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 *Covered Services* sections of this *Contract* for detailed information.

DEFINITIONS

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

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

Advanced premium tax credit means the tax credit provided by the Affordable Care Act to help *you* afford health coverage purchased through the 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're* due, *you'll* get the difference as refundable credit when *you* file *your* federal income tax return. If *your* advance payments for the year are more than the amount of *your* credit, *you* must repay the excess advance payments with *your* tax return.

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

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

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

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

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

Please note, if *you* receive services from a *non-network provider*, *you* may be responsible for the difference between the amount the provider charges for the service (*billed amount*) and the *allowed amount* that *we* pay. 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*

hospital, or in-network ambulatory surgical facility, unless you gave informed consent before receiving the services. You also will not be responsible for balance billing by a non-network provider or non-network facility for emergency services or air ambulance services. 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 HP Specific Teladoc website link.

Appeal shall mean a formal request, either orally, or in writing or by electronic transmission, to reconsider a determination not to certify an admission, extension of stay, or other health care service or procedure, and shall include both formal standard *appeals* and expedited *appeals*.

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

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

Authorized Representative means an individual who represents a covered person in an *internal appeal* or external review process of an *adverse benefit determination* who is any of the following:

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

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

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

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

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.

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

Center of Excellence means a *hospital* that:

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

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

Complaint shall mean a communication from the enrollee or *member* either orally, in writing or by electronic transmission concerning dissatisfaction by the enrollee or *member* with the health plan or its providers.

Complications of pregnancy means:

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

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

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

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 percentage means the percentage of covered services that is payable by us.

Cost sharing reductions lower the amount you have to pay in *deductibles*, *copayments*, and *coinsurance*. To qualify for *cost sharing* reductions, an eligible individual must enroll in a silver level plan through the 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 service or **covered service expenses** are healthcare services, supplies or treatment as described in this *contract* which are performed, prescribed, directed, or *authorized* by a *provider*. To be a *covered service* the service, supply or treatment must be

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

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

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

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

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 amounts*; or
2. Your family satisfies the family *deductible amount* for the calendar year.

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

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

Dependent member means your lawful spouse or an eligible child.

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

Effective date (also known as *Effectuation date*) means the date a *member* becomes covered under this contract for *illness* or *injury*.

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

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption; or
4. A child for whom legal guardianship has been awarded to *you* or *your spouse*. It is *your* responsibility to notify the entity with which *you* enrolled (either the Marketplace or *us*) if *your* child ceases to be an *eligible child*. *You* must reimburse *us* for any benefits that *we* provide or pay for a child at a time when the child did not qualify as an *eligible child*.

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

1. For *network providers*: When a *covered service* is received from a *network provider*, the *eligible service expense* is the contracted fee with that provider.
2. For *non-network providers*, unless otherwise required by Federal or Georgia law, the *eligible service expense* is as follows:
 - a. When a *covered service* is received from a *non-network provider* as a result of an emergency, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the provider as payment in full (*you* will not be billed for the difference between the negotiated fee and the provider's charge). However, if the provider has not agreed to accept a negotiated fee with *us* as payment in full, the *eligible service expense* is the greatest of the following:
 - i. the verifiable median contracted amount paid by all eligible insurers for the same or similar services, calculated by a vendor utilized and chosen by the Georgia Office of the Insurance Commissioner,
 - ii. the most recent verifiable amount agreed to *us* and the *non-network provider* who rendered the *emergency services* for the same service during which time that provider was *in-network* with *us* (if applicable), or
 - iii. a higher amount that *we* may deem appropriate given the complexity and circumstances of the services provided by the provider.

You cannot be balance billed by the *non-network provider*, but *you* will be required to pay all cost-sharing amounts for these services. If *you* are balance billed in these situations, please contact Member Services immediately at the number listed on the back of *your* ID card.

- b. When a *covered service* is received from a *non-network 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 (*you* will not be billed for the difference between the negotiated fee and the provider's charge). If there is no negotiated fee agreed to by the provider with *us*, the *eligible service expense* is the greater of

- i. the verifiable median contracted amount paid by all eligible insurers for the same or similar services, calculated by a vendor utilized and chosen by the Georgia Office of the Insurance Commissioner,
- ii. the most recent verifiable amount agreed to *us* and the *non-network provider* who rendered the *non-emergency services* for the same service during which time that provider was in-network with *us* (if applicable), or
- iii. a higher amount that *we* may deem appropriate given the complexity and circumstances of the services provided by the provider.

You cannot be balance billed by the *non-network provider*, but *you* will be required to pay all cost-sharing amounts for these services. If *you* are balance billed in these situations, please contact Member Services immediately at the number listed on the back of *your* ID card.

- c. For all other *covered services* received from a *non-network provider* for which any needed *authorization* is received from *us*, the *eligible service expense* is the lesser of: (1) the negotiated fee, if any, that has been mutually agreed upon by *us* and the provider; or (2) the greatest of the following: (i) the amount that would be paid under Medicare; (ii) the amount for the *covered service* calculated using the same method *we* generally use to determine payments for out of *network providers*; or (iii) the contracted amount paid to in-network providers for the *covered service* (if there is more than one contracted amount with in-network providers for the *covered service*, the amount is the median of these amounts). In addition to applicable cost-sharing, *you* may be balance billed for these services.

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

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

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.

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 *contract* are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or annual dollar maximum. *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*.
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 (USFDA) regulation, regardless of whether the trial is subject to USFDA oversight.
2. An *unproven service*.
3. Subject to USFDA approval, and:
 - a. It does not have USFDA approval;
 - b. It has USFDA approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
 - c. It has USFDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a USFDA-approved drug is a use that is determined by us to be:
 - i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
 - ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
 - iii. Not an *unproven service*; or
 - d. It has USFDA approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the USFDA or has not been determined through peer reviewed medical literature to treat the medical condition of the *member*.
4. *Experimental or investigational* according to the provider's research protocols.

Items (3) and (4) above do not apply to phase I, II, III or IV USFDA clinical trials.

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 *provider* 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 *provider*; and

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

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

External Independent Review: An external third-party binding review by an Independent Review Organization (IRO) performed after the plan's internal *grievance/appeal* process has been exhausted, as applicable, and defined by the state regulations for all medical necessity denials. The request may be concurrent in the case of expedited *appeals*.

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 *provider* specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a healthcare service, supply, or drug is *medically necessary* and is a *covered service* under the *contract*. The decision to apply *provider* specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

Grievance Procedure means the process by which *appeals* are resolved.

Habilitation or habilitation services means health care services that help *you* keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* or *outpatient* settings.

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

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

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

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

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 *provider*, in accordance with existing standards of medical practice for the *injury* or *illness* requiring the *home health care*.

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

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

Hospital means an institution that:

1. Operates as a *hospital* pursuant to law;
2. Operates primarily for the reception, care, and treatment of sick or injured persons as *inpatients*;
3. Provides 24-hour nursing service by registered nurses on duty or call;
4. Has staff of one or more *providers* available at all times;
5. Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or in facilities available to it on a prearranged basis; and
6. Is not primarily a long-term care facility; an *extended care facility*, nursing, rest, *custodial care*, or convalescent home; a halfway house, transitional facility, or *residential treatment facility*; a facility for wilderness or outdoor programs; or a similar establishment.

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

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

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

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

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

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

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

Internal Appeal: A review request received in writing from a member or their *authorized representative* of any adverse benefit determination.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medically stabilized 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).

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

Member 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 *member*.

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

Necessary medical supplies means medical supplies that are:

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

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

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

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

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

Non-elective caesarean section means:

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

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

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

1. *Emergency Services*, as described in the *Covered Services* section of this *Contract*;
2. Non-emergency healthcare services received at an *in-network* facility, as described in the Access to Care section of this *Contract*; or
3. Situations otherwise specifically described in this *Contract*.

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

Other plan means any plan or policy that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, automobile no-fault or medical pay, homeowner insurance medical pay, premises medical pay,

nonprofit health service plans, health maintenance organization subscriber *contracts*, self-insured group plans, prepayment plans, and Medicare when the *member* is enrolled in Medicare. *Other plan* will not include Medicaid.

Other Practitioner 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 *provider* or other professional.

Outpatient surgical facility means any facility with a medical staff of *providers* 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 *provider* offices.

Period of extended loss means a period of consecutive days:

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

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

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 *provider*, 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, respiratory therapy or cardiac *rehabilitation*.

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

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

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.

Schedule of Benefits means a summary of the *deductible amounts, copayment amounts, cost sharing percentages*, maximums and other limits that apply when *you* receive *covered services*.

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

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

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

Substance use disorder means alcohol, drug or chemical abuse, overuse, or dependency. Covered *substance use disorders* are those listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or the most recent edition of the International Classification of Diseases, Tenth Revision (ICD-10).

Surgery or **surgical procedure** means:

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

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

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

Surveillance tests for ovarian cancer means annual screening using:

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

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

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 *provider* has given a prognosis that a *member* has six months or less to live.

Third party means a person or other entity that is or may be obligated or liable to the *member* for payment of any of the *member's* expenses for *illness* or *injury*. The term "*third party*" includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company.

However, the term "*third party*" will not include any insurance company with a policy under which the *member* is entitled to benefits as a named insured person or an insured *dependent member* of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit *our* right to recover from these sources.

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

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

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

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

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

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

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

DEPENDENT MEMBER COVERAGE

Dependent Member Eligibility

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

1. The date *you* became covered under this *contract*; 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 *dependent members* included in the application for this *contract* will be covered on *your effective date*.

Coverage for a Newborn Child

An *eligible child* born to *you* or *your family member* will be covered from the time of birth until the 31st day after its birth, unless *we* have received notice from the entity that *you* have enrolled (either the Marketplace or *us*). Each type of *covered service* incurred by the newborn child will be subject to the *cost sharing* amount listed in the *Schedule of Benefits*.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth. The required premium will be calculated from the child's date of birth. If notice of the newborn is given to *us* by the Marketplace within the 31 days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 days after the birth of the child. If notice is not given with the 31 days from birth, *we* will charge an additional premium from the date of birth. If notice is given by the 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 by the Marketplace of the child's birth.

Coverage for an Adopted Child

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

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

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

As used in this provision, "*placement*" 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.

Coverage for Other *Dependent Members*

If *you* are enrolled in an off-exchange policy and apply in writing for coverage on a *dependent member* 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* to 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 *allowed amount* applicable to non-contracted *hospitals*, and *you* may be billed for any balance of costs above the Ambetter *allowed amount*.

ONGOING ELIGIBILITY

For All Members

A *member's eligibility* for coverage under this *contract* will cease on the earlier of:

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this policy;
2. The primary *member* residing outside the service area or moving permanently outside the service area of this plan;
3. The date *we* receive a request from *you* to terminate this *contract*, or any later date stated in *your* request;
4. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *contract* or the date that *we* have not received timely premium payments in accordance with the terms of this *contract*;
5. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact (e.g. the date that a *member* accepts any direct or indirect contributions or reimbursement by or on behalf of an employer, for any portion of the premium for coverage under this *contract*); or
6. The date of a *member's* death.

For Dependent Members

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

We must receive notification within 90 days of the date a *dependent member* ceases to be an eligible *dependent member*. If notice is received by *us* more than 90 days from this date, any unearned premium will be credited only from the first day of the *policy*/calendar month in which *we* receive the notice.

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

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

Open Enrollment

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

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

1. The *qualified individual* has not been determined eligible for *advanced premium tax credit* or *cost-sharing reductions*; or
2. The *qualified individual* pays the entire premium for the first partial month of coverage as well as all *cost sharing*, thereby waiving the benefit of *advanced premium tax credit* and *cost-sharing reduction* payments until the first of the next month.

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, please contact Member Services at 1-877-687-1180 with any questions related to *your* health insurance coverage

Coverage Effective Dates for Special Enrollment Periods

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

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

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

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

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

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

PREMIUMS

Premium Payment

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

Grace Period

When a *member* is receiving a premium subsidy:

After the first premium is paid, a grace period of 90 days from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if *advanced premium tax credits* are received.

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

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

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

Third Party Payment of Premiums or Cost Sharing

Ambetter requires each policy holder 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 Center for Medicare and Medicaid Services (CMS) recommendations against accepting *third party* premiums. Consistent with CMS guidance, the following are the only acceptable third parties who may pay Ambetter premiums on *your* behalf:

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

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

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

Misstatement of Age

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

Change or Misstatement of Residence

If *you* change *your residence*, *you* must notify *us* of *your* new *residence* within 60 days of the change. *Your* premium will be based on *your* new *residence* beginning on the first premium due date/first day of the next calendar month after the change. If *your residence* is misstated on *your* application, or *you* fail to notify *us* of a change of *residence*, *we* will apply the correct premium amount beginning on the first premium due date/first day of the first full calendar month *you* resided at that place of *residence*. If the change results in a lower premium, *we* will refund any excess premium. If the change results in a higher premium, *you* will owe *us* the additional premium.

Misstatement of Tobacco or Nicotine Use

The answer to the *tobacco* or *nicotine* question on the application is material to *our* correct underwriting. If a *member's* use of *tobacco* or *nicotine* has been misstated on the *member's* application for coverage under this *contract*, *we* have the right to re-rate the *contract* back to the original *effective date*.

Billing/Administrative Fees

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

COST SHARING FEATURES

Cost Sharing Features

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

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

These rebates can be in the form a check or premium credit.

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.

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 non-covered services. *Copayments* do not count or apply toward the *deductible amount*, but do apply toward your *maximum out-of-pocket* amount.

Deductible

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

Maximum Out-of-Pocket

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

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

The amount provided or payable will be subject to:

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

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

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

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 *contract*.

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

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

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

Contacting Your Primary Care Physician

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

Should *you* need care outside of your *PCP's* office hours, *you* should call *your PCP's* office for information on receiving after hours care in *your* area. If *you* have an urgent medical problem or question or cannot reach *your PCP* during normal office hours, call *our* 24/7 nurse advice line at 1-877-687-1180 (TTY/TDD 1-877-941-9231). A licensed nurse is always available and ready to answer *your* health questions. In an emergency, call 911 or head straight to the nearest emergency room.

Changing Your Primary Care Physician (PCP)

You may change *your network primary care provider* for any reason, but not more frequently than once a month, by submitting a written request, online at *our* website at Ambetter.pshpgeorgia.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.

Network Availability

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

Coverage Under Other Policy Provisions

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

Non-Emergency Services

If *you* are traveling outside of the Ambetter 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 Georgia by searching the relevant state in our provider directory at <https://guide.ambetterhealth.com>. Not all states have Ambetter plans. If *you* receive care from an Ambetter provider outside of the service area, *you* may be required to receive *prior authorization* for non-emergency services. Contact Member Services at the phone number on *your* ID card for further information.

Emergency Services Outside of Service Area

We cover emergency care services when *you* are outside of *our* service area.

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

Continuity of Care

Under the No Surprises Act, if a *member* is receiving a *covered service* with respect to an *network* provider or facility and: (1) the contractual relationship with the provider or facility is terminated, such that the provider or facility is no longer in *network*; or (2) benefits are terminated because of a change in the terms of the participation of the provider or facility, as it pertains to the benefit the *member* is receiving, then *we* will: (1) notify each enrollee who is a *continuing care patient* on a timely basis of the termination and their right to elect continued transitional care from the provider or facility; (2) provide the individual with an opportunity to notify the health plan of the individual's need for transitional care; and

(3) permit the individual to elect to continue to have their benefits for the course of treatment relating to the individual's status as a *continuing care patient* during the period beginning on the date on which the above notice is provided and ending on the earlier of (i) the 90-day period beginning on such date; or the (ii) date on which such individual is no longer a *continuing care patient* with respect to their provider or facility.

New Technology

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

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

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

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

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

The Plan provides coverage for healthcare services for a *member* and/or dependents. Some services require preauthorization.

Copayment amounts must be paid to *your network provider* at the time *you* receive services.

All *covered services* are subject to conditions, exclusions, limitations, terms and provision of this policy. *Covered services* must be *medically necessary* and not *experimental* or *investigational*.

Benefit Limitations

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

Ambulance Service Benefits

Covered service expenses will include ambulance services for local ground 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 skilled nursing or *rehabilitation facility* and *member's* home when *authorized* by Ambetter.
4. When ordered by an employer, school, fire or public safety official and the *member* is not in a position to refuse; or
5. When a *member* is required by *us* to move from a *non-network provider* to a *network provider*.

Prior authorization is not required for emergency ambulance transportation. Note: Non-emergency ambulance transportation requires *prior authorization*. Unless otherwise required by Federal or Georgia 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 medical transportation. .
3. Ambulance services provided for a *member's* comfort or convenience.
4. Non-emergency transportation excluding ambulances (for example, transport-van, taxi).

Air Ambulance Service Benefits

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

1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*, in cases of *emergency*.
2. To the nearest 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.

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.

Ambulance Providers typically are not contracted within the Ambetter *network*. If *you* received services from an ambulance provider, there is a possibility *you* could be balanced billed. This applies to ground ambulance and air ambulance transportation.

Mental Health and Substance Use Disorder Benefits

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

If *you* need mental health or *substance use disorder* treatment, *you* may choose any provider participating in *our* behavior 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 Ambetter.pshpgeorgia.com or by calling Member Services at 1-877-687-1180 (TTY/TDD 1-877-941-9231). *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 disorders* are included on a non-discriminatory basis for all *members* for the diagnosis and treatment of mental, emotional, and/or *substance use disorders* as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

When making coverage determinations, *we* utilize an 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. *We* utilize "Interqual" criteria for mental health determinations and

American Society of Addiction Medicine (ASAM) criteria for *substance use disorder* determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

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

Inpatient

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

Outpatient

- Partial Hospitalization Program (PHP);
- Intensive *Outpatient* Program (IOP);
- Individual and group mental health evaluation and treatment;
- *Outpatient services* for the purpose of monitoring drug therapy;
- Medication management services;
- *Outpatient* detoxification programs;
- Psychological and Neuropsychological testing and assessment;
- *Outpatient rehabilitation* treatment;
- Electroconvulsive Therapy (ECT);
- *Applied Behavior Analysis* Based Therapies, for the treatment for *autism spectrum disorder*;
- Biofeedback;
- *Telehealth services*;
- Mental health day treatment;
- *Transcranial Magnetic Stimulation (TMS)*; and
- Assertive Community Treatment (ACT).

In addition, *Integrated Care Management* is available for all of *your* healthcare needs, including *behavioral health* and substance use. Please call 1-877-687-1180 (TTY/TDD 1-877-941-9231) to be referred to a care manager for an assessment.

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

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; or
- 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.

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

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

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

Alternative Care - Home Health Care or Hospice

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

1. *Home health aide services*.
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care*.
3. I.V. medication and pain medication to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.
4. Hemodialysis, and for the processing and administration of blood or blood components.
5. *Necessary medical supplies*.
6. Rental of *medically necessary durable medical equipment* at the discretion of the plan. 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.

7. Sleep studies.

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

Limitations:

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

Schedule of Benefits Exclusion:

No benefits will be payable for charges related to *custodial care*, or educational care.

Hospice Care Service Expense Benefits

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

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

Exclusions and Limitations:

Any exclusion or limitation contained in the *contract* 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.

Benefits for *hospice inpatient* or *outpatient* care are available to a *terminally ill covered person*.

Respite Care Expense Benefits

Respite care is covered on an *inpatient* or *outpatient* basis to allow temporary relief to family members from the duties of caring for a Covered Person. Respite days that are applied toward the *deductible amount* are considered benefits provided and shall apply against any maximum benefit limit for these services.

Hospital Benefits

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

1. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
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* for use only while *you* are *inpatient*.
6. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See *your Schedule of Benefits* for limitations.

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 contracted *urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *primary care provider* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-877-687-1180. 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.

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. If a provider does inappropriately balance bill *you*, please contact our Member services department at 1-877-687-1180 (TTY/TDD 1-877-947-9231).

Infertility Treatment

Infertility treatment is a *covered service expense* when medical services are provided to the *member* which are *medically necessary* for the diagnosis of infertility. This does not cover treatment or *surgical procedures* for infertility including artificial insemination, in vitro fertilization, and other types of artificial or surgical means of conception including drugs administered in connection with these procedures.

Medical and Surgical Benefits

Covered service expenses are limited to charges:

1. For *surgery* in a *provider's* office or at an *outpatient surgical facility*, including services and supplies.
2. Made by a *provider* 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.
7. For chemotherapy and radiation therapy or treatment.
8. For the cost and administration of an anesthetic including general anesthesia and associated facility charges for *dental services* rendered in a *hospital* or ambulatory *surgery facility* setting, provided that a *member* meets the following:
 - *Eligible Child* is seven years of age or younger or is developmentally disabled;
 - A *member* for which a successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition; or

- A *member* who has sustained extensive facial or dental trauma, unless otherwise covered by workers' compensation insurance.
9. For oxygen and its administration.
 10. For accidental *dental service expenses* when a *member* suffers an *injury*, after the *member's effective date* of coverage, that results in:
 - a. Damage to his or her natural teeth; and
 - b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *provider* and began within six months of the accident. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
 11. For *surgery* and treatment, excluding tooth extraction, of craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint.
 12. For a baseline mammogram for *members* 35 to 39 years of age. Breast Cancer Mammography screenings every 1 to 2 years for *members* over 40. A mammogram at the age and intervals considered *medically necessary* by the *member's* health care provider for *members* under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors.
 13. 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.
 14. For *medically necessary chiropractic care* treatment on an *outpatient* basis only. See the *Schedule of Benefits* for benefit levels or additional limits. Chiropractic Services are covered when a Participating Chiropractor finds that the services are *medically necessary* to treat or diagnose Neuromusculoskeletal Disorders on an *outpatient* basis. *Covered service expenses* are subject to all other terms and conditions of the *contract*, including the *deductible amount* and *coinsurance* percentage provisions.
 15. For the following types of tissue transplants:
 - a. Cornea transplants.
 - b. Artery or vein grafts.
 - c. Heart valve grafts.
 - d. Prosthetic tissue replacement, including joint replacements.
 - e. Implantable prosthetic lenses, in connection with cataracts.
 16. Family Planning for certain professional Provider contraceptive services and supplies, including but not limited to sterilization and vasectomies, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.
 17. Prescription glasses or contact lenses when required as a result of *surgery* or for the treatment of accidental *injury*.
 18. For approved clinical trial programs for the treatment of children's cancer which includes a Phase II and III *prescription drug* clinical trial program in the state of Georgia, as approved by the federal Food and Drug Administration or the National Cancer Institute for the treatment of cancer that generally first manifests itself in children under the age of 19 and that: Test new therapies, regimens, or combinations thereof against standard therapies or regimens for the treatment of cancer in children; Introduces a new therapy or regimen to treat recurrent cancer in children; or Seeks to discover new therapies or regimens for the treatment of cancer in children which are more cost effective than standard therapies or regimens. These treatments must be certified by and utilize the standards for acceptable protocols established by the Pediatric Oncology Group and the Children's Cancer Group.
 19. For Child wellness services. This includes the periodic review of a child's physical and emotional status conducted by a *provider* or conducted pursuant to a *provider's* supervision, but shall not include periodic dental examinations or other *dental services*. The review shall include a medical history, complete physical examination, developmental assessment, appropriate immunizations,

anticipatory guidance for the parent or parents, and laboratory testing in keeping with prevailing medical standards. These services are limited to an *eligible child* from birth through the age 19. Services which are rendered during a periodic review shall only be covered to the extent that such services are provided by or under the supervision of a single *provider* during the course of one visit.

20. Nutritional counseling for the treatment of obesity, which includes morbid obesity, limited to 4 visits per year.
21. For *medically necessary* genetic blood tests.
22. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
23. For *medically necessary* biofeedback services.
24. For *medically necessary* allergy treatment including allergy injection.
25. For *medically necessary telehealth services*.
26. Coverage for *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis;
27. *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.

Dialysis Services

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

Covered expenses include:

- Services provided in an *Outpatient* Dialysis Facility or when services are provided in the Home;
- Processing and administration of blood or blood components;
- Dialysis services provided in a *hospital*;
- Dialysis treatment of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

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

Diabetic Care Expense Benefits

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

Outpatient Medical Supplies Expense Benefits

Covered expenses for *outpatient* medical supplies are limited to charges:

1. For artificial eyes or 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*.
2. For one pair of foot orthotics per year per *covered person*. Coverage is limited to diabetes care only.
3. For four mastectomy bras per year if the covered person has undergone a covered mastectomy.
4. For rental of a *medically necessary durable medical equipment*.
5. For the cost of one Continuous Passive Motion (CPM) machine per covered person following a covered joint *surgery*.
6. For the cost of one wig per covered person necessitated by hair *loss* due to cancer treatments or traumatic burns.
7. For respiratory therapy and cardiac *rehabilitation*.
8. For one pair of eyeglasses or contact lenses per covered person following a covered cataract *surgery*.

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).

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*, he or she will only be responsible for the applicable *cost sharing* for the consultation. Any lab tests and/or diagnostic and therapeutic services are subject to the additional *cost sharing*. If a second medical opinion is obtained by a *non-network provider*, *prior authorization* must be obtained before services are considered an *eligible service expense*. If *prior authorization* is not obtained for a second medical opinion from a *non-network provider*, *you* will be responsible for the related expenses.

Prescription Drug Expense Benefits

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

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

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

Medication Balance-On-Hand

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

Split-Fill Dispensing Program

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

Lock-in Program

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

Formulary or Prescription Drug List

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

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

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the formulary. For the most current Ambetter Formulary or Prescription Drug List (PDL) or for more information about *our* pharmacy program, visit Ambetter.pshpgeorgia.com (under "For Member", "Pharmacy Resources") or call Member Services at 1-877-687-1180 (TTY/TTD 1-877-941-9231).

Over-the-Counter (OTC) Prescriptions

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

How to Fill a Prescription

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

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

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

Mail Order Pharmacy

If *you* have more than one prescription *you* take regularly, *you* may select to enroll in *our* mail order delivery program. *Your* prescriptions will be safely delivered right to *your* door at no extra charge to *you*. *You* will still be responsible for *your* regular *copayment/coinsurance*. To enroll for mail order delivery or for any additional questions, call *our* mail order pharmacy at 1-888-239-7690. Alternatively, *you* can fill out an enrollment form and mail the form to the address provided at the bottom of the form. The enrollment form can be found on *our* Ambetter website. Once on *our* website, click on the section, “For Member,” “Pharmacy Resources.” The enrollment form will be located under “Forms.”

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

For *your* health and wellness, we review the use of prescription medications. Ambetter’s Pharmacy department, together with Medical Management, will review *member* profiles. If *members* meet specific criteria, they will be recommended for participation in the Pharmacy Lock-In program. This program also helps to decrease overutilization. If we detect the pharmacy benefit is being used in a potentially harmful, excessive, or abusive manner, *your* coverage of pharmacy services may be limited in one or more of the following ways:

- By restricting *your* pharmacy services to a single specific in-*network* pharmacy;
- By restricting *your* specialty pharmacy services to a specific specialty pharmacy, if the specified in-*network* pharmacy is unable to provide or is not contracted to provide covered specialty pharmacy services;
- By restricting all of *your* controlled substance medications to be prescribed by a specific in-*network* health care practitioner

Once we determine it is necessary to restrict *your* pharmacy services, only prescriptions filled at the specified in-*network* pharmacy or in-*network* specialty pharmacy will be considered eligible covered expenses. Additionally, only controlled substance medications prescribed by the specified in-*network* health care practitioner will be considered eligible covered expenses. *Members* identified for participation in the Pharmacy Lock-In program, and their associated providers, will be notified of the program via mail.

Such communication will include information on duration of participation, pharmacy to which *member* is locked-in, any prescriber restrictions, and *member appeals* rights. We will review a request to change the selected in-*network* pharmacy or health care practitioner, then call and/or mail a letter to notify *you* if the change is allowed.

Non-Covered Services and Exclusions:

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

1. For *prescription drug* treatment of erectile dysfunction or any enhancement of sexual performance unless such treatment is listed on the formulary.
2. For weight loss *prescription drugs* unless otherwise listed on the formulary.

3. For immunization agents, blood, or blood plasma, except when used for preventative care and listed on the formulary.
4. For medication that is to be taken by the *member*, in whole or in part, at the place where it is dispensed.
5. For medication received while the *member* is a patient at an institution with a facility for dispensing pharmaceuticals.
6. For a refill dispensed more than 12 months from the date of a *physician's* order.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary.
9. For drugs labeled "Caution - limited by federal law to *investigational* use" or for *investigational* or *experimental* drugs.
10. For any drug that *we* identify as therapeutic duplication through the Drug Utilization Review program.
11. For more than a 30-day supply when dispensed in any one prescription or refill, or for some maintenance drugs up to 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply *network*. Specialty drugs and other select drug categories are limited to a 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;
12. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
13. Foreign prescription medications, except those associated with an *emergency* medical condition while *you* are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this document if obtained in the United States.
14. 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.
15. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
16. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventative treatment is related to *member's* vacation during out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
17. For medications used for cosmetic purposes.
18. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status. To facilitate appropriate benefit use and prevent overutilization, *member's* participation in lock-in status will be determined by review of pharmacy claims.
19. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
20. For infertility drugs unless otherwise listed on the formulary.
21. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
22. For drugs or dosage amounts determined by Ambetter to be ineffective, unproven, or unsafe for the indication for which they have been prescribed, regardless of whether such drugs or dosage amounts have been approved by any governmental regulatory body for that use.
23. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at a dental practitioner's office.
24. For any drug dispensed from a non-lock-in pharmacy while *member* is in lock-in program.

25. For any drug related to *surrogate pregnancy*.
26. For any medicinal and recreational use of cannabis or marijuana.
27. For any injectable medication or biological product that is not expected to be self-administered by the *member* at *member's* place of *residence* unless listed on the formulary.
28. Medication refills where a *member* has more than 15 days' supply of medication on hand.

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.

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.

Prescription Drug Exception Process

Standard exception request

A *member*, a *member's* designee or a *member's* prescribing *provider* 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 *provider* 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 *provider* 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 *provider* with *our* coverage determination. Should the standard exception request be granted, *we* will provide coverage of the non-formulary drug for the duration of the exigency.

External exception request review

If *we* deny a request for a standard exception or for an expedited exception, the *member*, the *member's* designee or the *member's* prescribing *provider* 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 *provider* 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.

Pediatric Vision Expense Benefits

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

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

Please refer to your *Schedule of Benefits* for a detailed list of *cost sharing*, annual maximum, and appropriate service limitations. To see which vision providers are part of the *network*, please visit ambetter.pshpgeorgia.com or call Member Services at 1-877-687-1180 (TTY/TDD 1-877-941-9231).

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

Preventive Care Expense Benefits

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

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force which includes cervical cancer and HPV screening, colorectal cancer screening, ovarian cancer screening, prostate cancer screening and mammography screening.

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.

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

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

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

If a service is considered non-preventive, *your contract'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.

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

Bone Mass Measurement/Bone Density Testing

Covered service expenses include the charges incurred by a *member* for bone mass measurements or bone density testing, and *prescription drugs* and devices approved by the FDA or generic equivalents as approved substitutes. Bone mass measurements or bone density testing, drugs or devices shall include those *members* who meet the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. *Members* will also qualify if the *member* meets any of the following:

1. Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
2. With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or
3. On a prescribed drug regimen posing a significant risk of osteoporosis; or
4. With lifestyle factors to a degree as posing a significant risk of osteoporosis; or,
5. With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

Maternity Care

An *inpatient* stay is covered for mother and newborn for a minimum of 48 hours following a vaginal delivery and 96 hours following a delivery by cesarean section will require notification to the Health Plan. We do not require that a *provider* or other healthcare provider obtain *prior authorization for delivery*.

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.

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

- a. *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.
- b. *Provider* home visits and office services.
- c. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
- d. *Complications of pregnancy*.
- e. *Hospital* stays for other *medically necessary* reasons associated with maternity care.
- f. For medical services or supplies for maternity deliveries at home, required for medical professional or *medically necessary* treatment.

Note: This provision does not amend the *contract* to restrict any terms, limits, or conditions that may otherwise apply to *covered services* expense for maternity care. This provision also does not require an enrollee who is eligible for coverage under a health benefit plan to:

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

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

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 at the Member Services Department, 1100 Circle 75 Parkway, Suite 1100 Atlanta, GA 30339. In the event that a *member* fails to comply with this provision, we reserve our right to enforce this EOC on the bases of fraud, misrepresentation, or false information, up to and including recoupment of all benefits that we paid on behalf of the *Surrogate* during the time that the *Surrogate* was insured under our policy, plus interest, attorneys' fees, costs, and all other remedies available to us.

Newborns' and Mothers' Health Protection Act Statement of Rights

Health insurance issuers generally may not, under federal law, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain *authorization* from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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:

1. The *investigational* item or service itself;
2. 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
3. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

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

1. 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
2. The insured is enrolled in the clinical trial. This section shall not apply to insurers who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

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

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

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

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

Transplant Benefits

Covered services For Transplant Service Expenses:

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

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

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

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

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

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

Ancillary "*Center Of Excellence*" Service Benefits:

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

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

Non-Covered Services and Exclusions:

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

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

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

- a. Alcohol/*tobacco*
- b. Car Rental (unless pre-approved by Case Management)
- c. Vehicle Maintenance for motorized and hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, ect.)
- d. Parking, such as but not limited to hotel, valet or any offsite parking other than *hospital*.
- e. Storage rental units, temporary housing incurring rent/mortgage payments.
- f. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, ect.
- g. Speeding tickets
- h. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
- i. For any services related to pet care, boarding, lodging, food, and/or travel expenses; other than those related to certified/registered service animal(s).
- j. Expenses for persons other than the patient and his/her covered companion
- k. Expenses for lodging when *member* is staying with a relative
- l. Any expense not supported by a receipt
- m. Upgrades to first class travel (air, bus, and train)
- n. Personal care items (e.g., shampoo, deodorant, clothes)
- o. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA precheck, and early check-in boarding fees, extra baggage fees.
- p. Souvenirs (e.g., t-shirts, sweatshirts, toys)
- q. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type.
- r. All other items not described in the policy as eligible expenses
- s. Any fuel costs / charging station fees for electric cars.

Organ Transplant Medication Notification

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

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

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

Durable Medical Equipment, Prosthetics, and Orthotic Devices

The supplies, equipment and appliances described below are *covered services* under this benefit. If the supplies, equipment, and appliances include comfort, luxury, or convenience items or features which exceed what is *medically necessary* in *your* situation or needed to treat *your* condition, reimbursement will be based on the maximum allowable amount for a standard item that is a *covered service*, serves the same purpose, and is *medically necessary*. Any expense that exceeds the maximum allowable amount for the standard item which is a *covered service* is *your* responsibility. For example, the reimbursement for a

motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates *your* condition. Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by *us*. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

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 a *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 *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/cold pack pump.
3. Raised toilet seats.
4. Rental of equipment if the *member* is in a facility that is expected to provide such equipment.
5. Translift chairs.
6. Treadmill exerciser.
7. Tub chair used in shower.
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. 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.
3. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
4. 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.
5. Cochlear implant and Bone Anchored Hearing Aids.
6. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
7. Restoration prosthesis (composite facial prosthesis).
8. Wigs (the first one following cancer treatment, not to exceed one per benefit period), when purchased through a participating provider.

Exclusions:

Non-covered Prosthetic appliances include but are not limited to:

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

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. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant)
3. Ankle foot orthosis.
4. Corsets (back and special surgical).
5. Splints (extremity).
6. Trusses and supports.
7. Slings.
8. Wristlets.
9. Built-up shoe.
10. Custom made shoe inserts. Coverage is only for diabetic care only.

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

Exclusions:

Non-covered services include but are not limited to:

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

Social Determinants of Health Supplemental Benefits

Social determinants of health supplemental benefits and services may be offered to enrollees to remove barriers to accessing health services and improve overall health outcomes. These are benefits and services that we may make available in connection with this *contract*. The benefits and services provided may include transportation to health services, assistance with childcare, access to healthy meals, and other relevant services based on need.

The benefits are available as long as coverage remains active, unless changed by *us*. Upon termination of coverage, the benefits are no longer available. All enrollees are eligible for the benefits upon obtaining coverage. The services are optional, and the benefits are made available at no additional cost to the enrollees. The benefits and services available at any given time are made part of this *contract* by this reference and are subject to change by *us* through an update to information available on *our* website or by contacting *us*.

Social determinants of health benefits and services may be offered to enrollees through the “My Health Pays” wellness program and through local health plan websites. Enrollees may receive notifications about available benefits and services through emails from local health plans and through the “My Health Pays” notification system. To inquire about these benefits and services or other benefits available, *you* may visit *our* website at Ambetter.pshpgeorgia.com or by contacting Member Services by telephone at 1-877-687-1180 (TTY/TDD 1-877-941-9231).

Wellness and Other Program Benefits

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

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

You may obtain information regarding the particular programs available at any given time by visiting *our* website at Ambetter.pshpgeorgia.com or by contacting Member Services by telephone at 1-877-687-1180 (TTY/TDD 1-877-941-9231). The benefits are available as long as coverage remains active, unless changed by *us* as described in the programs’ terms and conditions. Upon termination of coverage, program benefits are no longer available. All enrollees are automatically eligible for program benefits upon obtaining coverage. The programs are optional, and the benefits are made available at no additional cost to the enrollees. The programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change by *us* through updates available on *our* website or by contacting *us*.

Care Management Programs

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

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

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

If *you* think *you* could benefit from *our Care Management* program, please call Member Services at 1-877-687-1180 (TTY/TDD 1-877-941-9231).

Medical Foods

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

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

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 *contract* for details regarding Coverage for a Newborn Child/Coverage for an Adopted Child.

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.

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

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

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

1. Administered or ordered by a *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 service expenses will not include, and no benefits will be provided or paid for any charges that are incurred:

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*, except as expressly provided for under the Benefits After Coverage Terminates clause in this *contract's* Termination section.
2. For any portion of the charges that are in excess of the *eligible service expense*.
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*.
4. For cosmetic breast reduction or augmentation, except for the *medically necessary* treatment of gender dysphoria.
5. Reversal of sterilization and reversal of vasectomies.
6. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
7. For expenses for television, telephone, or expenses for other persons.
8. For religious, sex counseling, 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 medical service 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 *contract* or is performed to correct a birth defect in a child who has been a *member* from its birth until the date *surgery* is performed.
13. Mental health services are excluded for:
 - a. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities
 - b. Pre-marital counseling
 - c. Court ordered care or testing, or required as a condition of parole or probation. Benefits will be allowed for services that are *medically necessary* and would otherwise be covered under this policy;

- d. Testing of aptitude, ability, intelligence, or interest
- 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 Service Expense Benefits.
- 15. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
- 16. While confined primarily to receive *rehabilitation, custodial care*, educational care, or nursing services (unless expressly provided for in this *contract*).
- 17. For vocational or recreational therapy, vocational *rehabilitation, outpatient* speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
- 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, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
- 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 treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of (90) consecutive days.
- 22. As a result of an *injury or illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's* workers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
- 23. For fetal reduction *surgery*.
- 24. Except as specifically identified as a *covered service expense* under the *contract*, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
- 25. 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; racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).
- 26. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or *member* of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
- 27. As a result of any *injury* sustained while at a *residential treatment facility*.
- 28. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
- 29. For the following miscellaneous items: care or complications resulting from non-covered services; chelating agents; domiciliary care; food and food supplements; routine foot care, foot orthotics or corrective shoes except for when provided in the treatment of diabetes; 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; private duty nursing; *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 *contract*.

30. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
31. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status. To facilitate appropriate benefit use and prevent overutilization, *member's* participation in lock-in status will be determined by review of pharmacy claims.
32. *Surrogacy Arrangement*. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a *member*, and any child born as a result of a *surrogacy arrangement*. This exclusion applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
 - (a) Prenatal care;
 - (b) Intrapartum care (or care provided during delivery and childbirth);
 - (c) Postpartum care (or care for the *surrogate* following childbirth);
 - (d) Mental Health Services related to the *surrogacy arrangement*;
 - (e) Expenses relating to donor semen, including collection and preparation for implantation;
 - (f) Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
 - (g) Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
 - (h) Preimplantation genetic diagnosis relating to a *surrogacy arrangement*;
 - (i) Any complications of the child or *surrogate* resulting from the *pregnancy*; or
 - (j) Any other health care services, supplies and medication relating to a *surrogacy arrangement*.

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

33. Immunizations that are not *medically necessary* or medically indicated. This includes those used for travel and occupational.
34. For expenses, services, and treatments from a massage therapist to touch and manipulate the muscles and other soft tissues of the body.
35. For expenses, services, and treatments from a Naprapathic *specialists* for conditions caused by contracted, injured, spasmed, bruised, and/or otherwise affected myofascial or connective tissue.
36. For expenses, services, and treatments from a Naturopathic *specialists* for treatment of prevention, self-healing and use of natural therapies.
37. For expenses, services, and treatments related to private duty nursing in an *inpatient*, outpatient, or home location.

PRIOR AUTHORIZATION

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

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

Prior Authorization Required

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

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

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

Prior Authorization requests (medical and *behavioral health*) must be received by telephone, efax or provider web 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 any *inpatient* admission, including emergent *inpatient* admissions.
5. At least 5 days prior to the start of *home health care* except those *members* needing *home health care* after *hospital* discharge.

After *prior authorization* has been requested and all required or applicable documentation has been submitted, *we* will notify *you* and *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* admission.
2. For urgent *concurrent reviews* within 24 hours of receipt of the request.
3. For urgent *pre-service reviews*, within 72 hours from date of receipt of request.
4. For non-urgent *pre-service reviews* within 5 days but no longer than 15 days of receipt of the request.
5. For post-service or *retrospective reviews*, within 30 calendar days of receipt of the request.

How to Obtain Prior Authorization

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

Failure to Obtain Prior Authorization

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

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

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 *contract*.

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*.

Services from Non-Network Providers

Except for *emergency* medical services, *we* do not normally cover services received from *non-network providers*. If a situation arises where a *covered service* cannot be obtained from a *network provider* located within a reasonable distance, *we* may provide a *prior authorization* for *you* to obtain the service from a *non-network provider* at no greater cost to *you* than if *you* went to a *network provider*. If *covered services* are not available from a *network provider*, *you* or *your primary care provider* must request *prior authorization* from *us* before *you* receive services from a *non-network provider*. Otherwise, *you* will be responsible for all charges incurred.

Hospital Based Providers

When receiving care at an Ambetter participating *hospital* it is possible that some *hospital*-based providers (for example, anesthesiologists, radiologists, pathologists) may not be under *contract* with Ambetter as participating providers. If appropriate notice is provided to and acknowledged by *you* before rendering services, these providers may bill *you* for the difference between Ambetter's *allowed amount* and the providers billed charge – this is known as "*balance billing*". *We* encourage *you* to inquire about the providers who will be treating *you* before *you* begin *your* treatment, so *you* can understand their participation status with Ambetter.

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 providers 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.

Prior Authorization Denials

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

TERMINATION

Termination of Contract

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*; or
2. The date *we* receive a request from *you* to terminate this *contract*, or any later date stated in *your* request; or
3. For a dependent child reaching the limiting age of 26, coverage under this *contract*, for a dependent child, will terminate at 11:59 p.m. on the last day of the year in which the dependent child reaches the limiting age of 26.
4. The date *we* decline to renew this *contract*, as stated in the Discontinuance provision.
5. The date of *your* death, if this *contract* is an Individual Plan; or
6. The date a *member's eligibility* for coverage under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.

Refund upon Cancellation

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

Discontinuance

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

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

Notification Requirements

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

Continuation of Coverage

We will issue the continuation of coverage:

1. No less than 30 days prior to a *member's* 26th birthday; or
2. Within 30 days after the date *we* receive timely notice of *your* legal divorce or *dependent member's* marriage. *Your* former *dependent member* must pay the required premium within 31 days following notice from *us* or the new *contract* will be void from its beginning.

REIMBURSEMENT

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

However, if payment by or for the *third party* has not been made by the time we receive acceptable *proof of loss*, we will pay regular *contract* benefits for the *member's loss*. We will have the right to be reimbursed to the extent of benefits we provided or paid for the *illness or injury* if the *member* subsequently receives any payment from any *third party*. The *member* (or the guardian, legal representatives, estate, or heirs of the *member*) shall promptly reimburse us from the settlement, judgment, or any payment received from any *third party*.

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

1. To fully cooperate with us in order to obtain information about the *loss* and its cause.
2. To immediately inform us in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.
3. To include the amount of benefits paid by us on behalf of a *member* in any claim made against any *third party*.
4. That we:
 - a. Will have a lien on all money received by a *member* in connection with the *loss* equal to the benefit amount we have provided or paid.
 - b. May give notice of that lien to any *third party* or *third party's* agent or representative.
 - c. Will have the right to intervene in any suit or legal action to protect *our* rights.
5. To take no action that prejudices *our* reimbursement and subrogation rights.
6. To sign, date, and deliver to us any documents we request that protect *our* reimbursement rights.
7. To not settle any claim or lawsuit against a *third party* without providing us with written notice of the intent to do so.
8. 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.
9. That we may reduce other benefits under the *contract* by the amounts a *member* has agreed to reimburse us.

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

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-office 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 Ambetter.pshpgeorgia.com under "Member Resources". Send all the documentation to *us* at the following address:

Ambetter
Attn: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

Cooperation Provision

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

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

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

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

Time for Payment of Claims

Benefits will be paid within 30 days after receipt of proper *proof of loss*.

Payment of Claims

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

We may elect to pay, in *our* discretion, all or any part of the benefits provided by this *contract* for *hospital*, surgical, nursing, or medical services, directly to the *hospital* or other party providing such services to *you*. By reserving the right to pay, in *our* discretion, all or any part of the benefits provided for in this *contract* directly to a *hospital* or other person providing surgical, nursing, or medical services to *you*, *we* are not granting any *hospital* or other person rendering surgical, nursing, or medical services any right to demand direct payment of any right to enforce any provision of this *contract*; nor are *we* waiving the Non-Assignment provision of this *contract* set forth below.

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

Foreign Claims Incurred For Emergency Care

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

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

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

Non-Assignment

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

No Third Party Beneficiaries

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

Medicaid Reimbursement

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

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

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

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

Custodial Parent

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

Upon request by the custodial parent, we will:

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

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

Physical Examination

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

Legal Actions

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

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

Appeal and Complaint Procedure

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

Applicability/Eligibility

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

An eligible complainant 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 appeal*: the person for whom the insured has verbally given *authorization* to represent the claimant.

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

Call Member Services

Please contact Member Services at 1-877-687-1180 (TTY/TDD 1-877-941-9231) if *you* have questions or concerns. We will attempt to answer *your* questions during initial contact, as most concerns can be resolved with one phone call.

Appeal

An *appeal* is a formal request, either orally, or in writing or by electronic transmission, to reconsider a determination not to certify an admission, extension of stay, or other health care service or procedure, and shall include both formal standard *appeals* and expedited *appeals*.

Filing an Appeal

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

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

Ambetter

Attn: Appeals and Grievances Department

1100 Circle 75 Parkway, Suite 1100

Atlanta, GA 30339

Fax 1-877-941-8071

You can also file an appeal via phone by contacting us at 1-877-687-1180 (TTY/TDD 1-877-941-9231). Verbal requests must be followed up in writing. You can also file an appeal via phone by contacting us at 1-877-687-1180 (TTY/TDD 1-877-941-9231). Verbal requests must be followed up in writing.

Call us at 1-877-687-1180 (TTY/TDD 1-877-941-9231) if you have any questions regarding the process or how to file an *appeal*. We will provide an interpreter or TTY/TDD services for you if you need them.

Processing your *Appeal*

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

Grievance Panel

Your *appeal* will be reviewed by a *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*.

An appellant 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.
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.

We may extend our deadline by no more than 14 calendar days if we need additional information to reach a decision. We will inform you of the request's status if such an extension is necessary. If we do not receive the required information within the extended timeframe, we will make a determination based on the information we have. If no extension is needed, we will make the decision within 30 calendar days.

calendar days of receipt of *your* pre-service *appeal* or 60 calendar days of receipt of *your* post-service *appeal*. We will resolve any appeals for *prescription drugs* excluded by the Ambetter Prescription Drug List (also referred to as the formulary) within 72 hours of receipt.

The notice will include an explanation of *our* decision, a reference to the criteria on which the decision was based, a list of the title and qualifications of each person participating in the review, and a description of *your* further *appeal* rights. *Your* further *appeal* rights include the right to an External Review.

Expedited Appeal

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

You may request an expedited appeal at any time. You may start the appeal orally or in writing. You may contact us at:

Ambetter from Peach State Health Plan

Attn: Appeals and Grievances Department

1100 Circle 75 Parkway, Suite 1100

Atlanta, GA 30339

Fax 1-877-941-8071

Customer Service: 1-877-687-1180 (TTY/TDD 1-877-941-9231)

All necessary information, including *our* determination on review, will be transmitted between the appellant and *us* by telephone, facsimile, or other available similarly expeditious method. Upon written request, *we* will mail or electronically mail a copy of the appellant's complete policy to the appellant or the appellant's *authorized representative* as expeditiously as the *grievance* is handled.

We will make a decision about the request within 72 hours of receipt. Due to the 72-hour resolution timeframe, the standard requirements for notification, *grievance* panel and acknowledgement do not apply to expedited *appeals*.

We will resolve any *appeals* for *prescription drugs* excluded by the Ambetter Prescription Drug List (also referred to as the formulary) within 72 hours of receipt.

External Review Process

1. *We* have five (5) business days (immediately for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether:
 - 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 (1) business day (immediately for expedited) after completion of the preliminary review, *we* will notify the claimant in writing as to whether the request is complete but not eligible for external review and the reasons for its ineligibility or, if the request is not complete, the additional information needed to make the request complete.
3. *We* must allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of notification.
4. *We* will assign an Independent Review Organization (IRO) on a rotating basis from *our* list of contracted IROs.
5. Within five (5) business days after the date of assignment of the IRO, *we* must provide the documents and any information considered in making the *adverse benefit determination* to the IRO.
Note: For expedited, after assignment of the IRO, *we* must provide the documents and any information considered in making the *adverse benefit determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method.
6. 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*.
7. Within 10 business days, the assigned IRO will timely notify the claimant in writing of the request's *eligibility* and acceptance for external review. The notice will include a statement that the claimant may submit in writing additional information to the IRO to consider.
8. Upon receipt of any information submitted by the claimant, the IRO must forward the information to *us* within one (1) business day.
9. 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 (1) business day after making such decision. The external review would be considered terminated.
10. Within 45 days (72 hours for expedited) after the date of receipt of the request for an external review by the health plan, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to the claimant and to *us*. If the notice for an expedited review is not in writing, the IRO must provide written confirmation within 48 hours after the date of providing the notice.
11. 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*.

Complaint

A *complaint* is a communication from the enrollee or *member* either orally, in writing or by electronic transmission concerning dissatisfaction by the enrollee or *member* with the health plan or its providers. *Complaints* commonly involve.

- a) *Us*, as the insurer; e.g., customer service grievances - "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;
- c) Expressions of dissatisfaction regarding quality of care/quality of service;

Contact Member Services at 1-877-687-1180 (TTY/TDD 1-877-941-9231) for any questions, concerns, or inquiries. Most concerns can be resolved upon initial contact without going through the formal *complaint* process.

Filing a *Complaint*

You or your authorized representative may file a complaint by calling Member Services at 1-877-687-1180 (TTY/TDD 1-877-941-9231) or in writing by mailing or faxing your complaint to:

Ambetter

Attn: Appeals and Grievances Department

1100 Circle 75 Parkway, Suite 1100

Atlanta, GA 30339

Fax 1-877-941-8071

If filing a written *complaint*, please include:

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

Process and Resolution Timeframes

We will acknowledge your complaint by sending you a letter within 5 business days of receipt of your complaint.

Complaints will be promptly investigated, and will be resolved within 30 calendar days of receipt. The time period may be extended for an additional 14 calendar days, making the maximum time for the entire *complaint* process 44 calendar days if we provide you or your authorized representative, if applicable, written notification of the following within the first 30 calendar days:

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

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

Complaints received from the State Insurance Department

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

Appeals and Complaint filing and key communication timelines

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
<i>Complaint</i>	N/A	5 business days	30 calendar days	14 calendar days
Standard Pre-Service Appeal	180 calendar days	5 business days	30 calendar days	14 calendar days
Expedited Pre-Service Appeal	180 calendar days	N/A	72 hours	14 calendar days
Standard Post-Service Appeal	180 calendar days	5 business days	60 calendar days	14 calendar days
Formulary Exception Request	180 calendar days	N/A	72 hours	14 calendar days
External Review	120 calendar days	6 business days	45 calendar days	N/A
Expedited External Review	120 calendar days	N/A	72 hours	N/A

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

GENERAL PROVISIONS

Entire Contract

This *contract*, with the application and any rider-amendments is the entire *contract* between *you* and *us*.

No party or agent of a party may:

1. Change or alter the terms of this *contract*;
2. Waive any provision of this *contract*;
3. Extend the time for payment of premiums;
4. Waive any of *our* rights or requirements under the *contract*; or
5. Waiver any of *your* obligations under the *contract*.

Non-Waiver

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

Rescissions

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

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

Repayment for Fraud, Misrepresentation or False Information

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

Conformity with State Laws

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

Construction

We have the full power, authority, and discretion to construe and interpret any and all provisions of this *contract* to the greatest extent allowed by applicable law.

Conditions Prior to Legal Action

On occasion, *we* may have a disagreement related to coverage, benefits, premiums, or other provisions under this *contract*. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process. Therefore, with a view to avoiding litigation, *you* must give written notice to *us* of *your* intent to sue *us* as a condition prior to bringing any legal action. *Your* notice must:

1. Identify the coverage, benefit, premium, or other disagreement;
2. Refer to the specific *contract* provision(s) at issue; and
3. Include all relevant facts and information that support *your* position.

Unless prohibited by law, *you* agree that *you* waive any action for statutory or common law extra-contractual or punitive damages that *you* may have if the specified contractual claims are paid, or the issues giving rise to the disagreement are resolved or corrected, within 30 days after *we* receive *your* notice of intention to sue *us*.

Personal Health Information (PHI)

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

We protect all oral, written and electronic PHI. *We* follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. *We* are required to notify *you* about these practices every year. This notice describes how *your* medical information may be used and disclosed and how *you* can get access to this information. Please review it carefully. If *you* need more information or would like the complete notice, please visit <https://ambetter.pshpgeorgia.com/privacy-practices.html> or call Member Services at 1-877-687-1180 (TTY/TDD 1-877-941-9231).

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

Language

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

Statement of Non-Discrimination

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

Ambetter from Peach State Health Plan:

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

If you need these services, contact Ambetter from Peach State Health Plan at 1-877-687-1180 (TTY/TDD 1-877-941-9231).

If you believe that Ambetter from Peach State Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ambetter from Peach State Health Plan Complaints Department, 1100 Circle 75 Parkway, Suite 1100, Atlanta, GA 30339, 1-877-687-1180 (TTY/TDD 1-877-941-9231), Fax 1-877-941-8071. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from Peach State Health Plan is available to help you. You can also file a civil rights *complaint* with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

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Declaración de no discriminación

Ambetter de Peach State Health Plan cumple con las leyes de derechos civiles federales aplicables y no discrimina basándose en la raza, color, origen nacional, edad, discapacidad, o sexo. Ambetter de Peach State Health Plan no excluye personas o las trata de manera diferente debido a su raza, color, origen nacional, edad, discapacidad, o sexo.

Ambetter de Peach State Health Plan:

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

Si necesita estos servicios, comuníquese con Ambetter de Peach State Health Plan a 1-877-687-1180 (TTY/TDD 1-877-941-9231).

Si considera que Ambetter de Peach State Health Plan no le ha proporcionado estos servicios, o en cierto modo le ha discriminado debido a su raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja ante: Ambetter from Peach State Health Plan Complaints Department, 1100 Circle 75 Parkway, Suite 1100, Atlanta, GA 30339, 1-877-687-1180 (TTY/TDD 1-877-941-9231), Fax 1-877-941-8071. Usted puede presentar una queja por correo, fax, o correo electrónico. Si necesita ayuda para presentar una queja, Ambetter de Peach State Health Plan está disponible para brindarle ayuda. También puede presentar una queja de violación a sus derechos civiles ante la Oficina de derechos civiles del Departamento de Salud y Servicios Humanos de Estados Unidos (U.S. Department of Health and Human Services), en forma electrónica a través del portal de quejas de la Oficina de derechos civiles, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o por correo o vía telefónica llamando al: 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).

Los formularios de queja están disponibles en <http://www.hhs.gov/ocr/office/file/index.html>.

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Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Peach State Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-687-1180 (TTY/TDD 1-877-941-9231).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Peach State Health Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-687-1180 (TTY/TDD 1-877-941-9231).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Peach State Health Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-687-1180 (TTY/TDD 1-877-941-9231)로 전화하십시오.
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Peach State Health Plan 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-877-687-1180 (TTY/TDD 1-877-941-9231)。
Gujarati:	જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter from Peach State Health Plan વિશે કોઈ પણ હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. કૃપાચિથ સાથે વાત કરવા માટે 1-877-687-1180 (TTY/TDD 1-877-941-9231) ઉપર કોલ કરો.
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Peach State Health Plan, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-877-687-1180 (TTY/TDD 1-877-941-9231).
Amharic:	እርስዎ ወይም እርስዎ የሚርዱት ሰው ስለ Ambetter from Peach State Health Plan ግብር ጥያቄ ካለዎት ያለምንም ወጪ በድንገታዎ ድጋፍ እንዲሁም መረጃ የማግኘት መብት አለዎት፤ እስተርጓሚ ለማነጋገር በ 1-877-687-1180 (TTY/TDD 1-877-941-9231) ይደውሉ፤
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from Peach State Health Plan के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-877-687-1180 (TTY/TDD 1-877-941-9231) पर कॉल करें।
French Creole:	Si oumenm, oubyen yon moun w ap ede, gen kesyon nou ta renmen poze sou Ambetter from Peach State Health Plan, ou gen tout dwa pou w jwenn ed ak enfòmasyon nan lang manman w san sa pa koute w anyen. Pou w pale avèk yon entèprèt, sonnen nimewo 1-877-687-1180 (TTY/TDD 1-877-941-9231).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Peach State Health Plan вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-877-687-1180 (TTY/TDD 1-877-941-9231).
Arabic:	إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from Peach State Health Plan، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-687-1180 (TTY/TDD 1-877-941-9231).
Portuguese:	Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from Peach State Health Plan, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-687-1180 (TTY/TDD 1-877-941-9231).
Persian:	اگر شما، یا کسی که به او کمک می کنید مؤالی در مورد Ambetter from Peach State Health Plan دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. برای صحبت کردن با مترجم با شماره 1-877-687-1180 (TTY/TDD 1-877-941-9231) تماس بگیرید.
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Peach State Health Plan hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-687-1180 (TTY/TDD 1-877-941-9231) an.
Japanese:	Ambetter from Peach State Health Plan について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-877-687-1180 (TTY/TDD 1-877-941-9231)までお電話ください。