



FROM



home state
health™

2022 Evidence of Coverage



Ambetter.HomeStateHealth.com

Ambetter from Home State Health
Individual EPO Health Benefit Plan
Issued and Underwritten by Celtic Insurance Company
Home Office: 11720 Borman Drive, St. Louis, MO 63146

Individual Member Contract

In this *contract*, "*you*", "*your*", "*yours*" or "*member*" will refer to the subscriber and/or any *dependents* enrolled in this *policy* and "*we*," "*our*," or "*us*" will refer to Home State Health.

TEN DAY RIGHT TO RETURN CONTRACT

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

AGREEMENT AND CONSIDERATION

We issued this *policy* and the corresponding *schedule of benefits* in consideration of the application and the payment of the first premium. We will provide benefits to *you*, the *member*, for covered *losses* due to *illness* or bodily *injury* as outlined in this *policy*. Benefits are subject to *policy* definitions, provisions, limitations and exclusions.

This *contract*, including the endorsements and the attached papers, if any, constitutes the entire *policy* of insurance. No change in this *policy* shall be valid until approved by an executive officer of the insurer and unless such *approval* be endorsed hereon or attached hereto. No agent has authority to change this *policy* or to waive any of its provisions.

GUARANTEED RENEWABLE

Annually, we must file this product, the cost share and the rates associated with it for *approval*. Guaranteed renewable means that *your* plan will be renewed into the subsequent year's approved product on the anniversary date unless terminated earlier in accordance with *policy* terms. *You* may keep this *policy* (or the new *policy* *you* are mapped to for the following year) in force by timely payment of the required premiums. In most cases *you* will be moved to a new *policy* each year, however, we may decide not to renew the *policy* as of the renewal date if: (1) we decide not to renew all *contracts* issued on this form, with a new *policy* at the same metal level with a similar type and level of benefits, to residents of the state where *you* then live; (2) we withdraw from the *service area* or reach demonstrated capacity in a *service area* in whole or in part; or (3) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *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 *policy* in the following events: (1) non-payment of premium; (2) a *member* is found to be in material breach of this *contract*; or (3) a change in federal or state law no longer permits the continued offering of such coverage, such as CMS guidance related to individuals who are Medicare eligible.

From time to time, we will change the rate table used for this *policy* form. Each premium will be based on the rate table in effect on that premium's due date. The *policy* plan, and age of *members*, type and level of benefits, and place of *residence* on the premium due date are some of the factors used in determining *your* premium rates. We have the right to change premiums however, all premium rates charged will be guaranteed for a rating period of at least 12 months.

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

This health benefit plan requires that all health care services be delivered by a participating provider in *our network*. Services rendered by an out-of-*network* provider are not covered under this plan, except for *emergency services* and two (2) sessions per year to a licensed psychiatrist, licensed psychologist, licensed professional counselor or a licensed clinical worker for the purpose of *diagnosis* or assessment of mental health.

As a cost containment feature, this *policy* contains *prior authorization* requirements. Benefits may be reduced or not covered if the requirements are not met. Please refer to the *schedule of benefits* and the **Prior Authorization Section.**

WARNING: If *you* or *your* family members are covered by more than one health care plan, *you* may not be able to collect benefits from both plans. Each plan may require *you* to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before *you* enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers *you* or *your* family.

IMPORTANT INFORMATION

This *policy* reflects the known requirements for compliance under The Affordable Care Act as passed on March 23, 2010. As additional guidance is forthcoming from the US Department of Health and Human Services, and the Missouri Department of Commerce and Insurance, those changes will be incorporated into *your* health insurance *policy*.

The coverage represented by this *policy* is under the jurisdiction of the Missouri Department of Commerce and Insurance

This policy does not include pediatric dental services. Pediatric dental coverage is included in some health plans, but can also be purchased as a standalone product. Please contact your insurance carrier or producer, or seek assistance through Healthcare.gov, if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

Should this *policy* be purchased Off the Health Insurance Marketplace, then any and all references to Health Insurance Marketplace are not applicable.

Celtic Insurance Company



Kevin J. Counihan, President

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INTRODUCTION

Welcome to Ambetter from Home State Health (“Ambetter”)! This *policy* is issued and underwritten by Celtic Insurance Company, and network access and administrative services are provided by Home State Health.

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

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

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

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

How to Contact Us
Ambetter from Home State Health
11720 Borman Drive
St. Louis, MO 63146

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. CST
Member Services 1-855-650-3789
TDD/TTY 711
Emergency 911
24/7 Nurse Advice Line 1-855-650-3789

Interpreter Services

Ambetter has a free service to help *members* who speak languages other than English. These services ensure that *you* and *your health care professional* 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 phone. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for oral interpretation, or to request materials in Braille or large font.

To arrange for interpreter services, please call Member Services at 1-855-650-3789, or for the hearing impaired (TDD/TTY 711).

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, call Member Services at 1-855-650-3789 (TDD/TTY 711).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting *you* as a *member*.
2. Encouraging open discussions between *you*, *your health care professional* and *your providers*.
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, and/or expected health or genetic status.

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

You have the right to:

1. Participate with *your providers* in decisions about *your* 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 *health care professionals* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your health care professional* 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 health care professional* about what might be wrong (to the level known), *treatment* and any known likely results. *Your primary care health care professional* 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 health care professional* will ask for *your approval* for *treatment* unless there is an *emergency* and *your* life and health are in serious danger.
8. Make recommendations regarding *member's* rights, responsibilities and policies.
9. Voice *complaints* or *appeals* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse *treatment* for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your health care professional(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 health care professional* 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 31 days before the *effective date* of the modifications. Such notices shall include the following:
 - a. Any changes in clinical review criteria; or
 - b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
13. A current list of *network providers*.
14. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
15. Adequate access to qualified *medical practitioners* and *treatment* or services regardless of age, race, creed, sex, sexual orientation, national origin or religion.
16. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
17. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
18. Refuse *treatment* to the extent the law allows. *You* are responsible for *your* actions if *treatment* is refused or if the *primary care health care professional's* instructions are not followed. *You* should discuss all concerns about *treatment* with *your primary care health care professional*. *Your primary care health care professional* can discuss different *treatment* plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
19. Select *your primary care health care professional* within the *network*. *You* also have the right to change *your primary care health care professional* or request information on *network providers* close to *your* home or work.
20. Know the name and job title of people giving *you* care. *You* also have the right to know which *health care professional* is *your primary care health care professional*.
21. An interpreter when *you* do not speak or understand the language of the area.
22. A second opinion by a *network provider* if *you* want more information about *your treatment* or would like to explore additional *treatment* options
23. Make advance directives for healthcare decisions. This includes planning *treatment* before *you* need it.
24. Advance directives are forms *you* can complete to protect *your* rights for medical care. It can help *your primary care health care professional* and other providers understand *your* wishes about *your* health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
 - a. Living Will
 - b. Health Care Power of Attorney
 - 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 the entire *policy*.
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 health care professional* 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* I.D. card and keep scheduled appointments with *your health care professional*, and call the *health care professional's* office during office hours whenever possible if *you* have a delay or cancellation.
 6. Know the name of *your assigned primary care health care professional*. *You* should establish a relationship with *your health care professional*. *You* may change *your primary care health care professional* 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 health care professionals* in developing mutually agreed upon *treatment* goals to the degree possible.
 9. Supply, to the extent possible, information that *we* and/or *your health care professionals* need in order to provide care.
 10. Follow the *treatment* plans and instructions for care that *you* have agreed on with *your health care professionals*.
 11. Tell *your health care professional* if *you* do not understand *your treatment* plan or what is expected of *you*. *You* should work with *your health care professional* 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 health care professional*.
 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* enrolled.
 15. Pay *your* monthly premium on time and pay all *deductible amounts, copayment amounts, or cost-sharing percentages* at the time of service.
 16. Inform the entity in which *you* enrolled for this *policy* if *you* have any changes to *your* name, address, or family members covered under this *policy* within 60 days from the date of the event.
 17. Notification of any enrollment related changes that would affect *your policy*, such as: birth of a child, or adoption, marriage, divorce, adding/removing a dependent, *spouse/domestic partner* becomes eligible under a different insurer, enrollment changes, or incarceration where member cost share would need to transfer from one policy to another policy.

IMPORTANT INFORMATION

Provider Directory

A listing of *network providers* is available online at <http://ambetter.homestatehealth.com/findadoc>. *We* have plan *health care professionals, hospitals, and other medical practitioners* who have agreed to provide *you* with *your* healthcare services. *You* may find any of *our network providers* by completing the “Find a Provider” function. There *you* will have the ability to narrow *your* search by provider specialty, zip code, gender, whether or not they are currently accepting new patients, and languages spoken. *Your* search will produce a list of providers based on *your* search criteria and will give *you* other information such as name, address, phone number, office hours, specialty, and board certifications.

At any time, *you* can request a copy of the provider directory at no charge by calling Member Services at 1-855-650-3789. *We* can help *you* pick a *primary care health care professional*. *We* can make *your* choice

of *primary care health care professional* effective on the next business day.

Call the *primary care health care professional's* office if *you* want to make an appointment. If *you* need help, call Member Services at 1-855-650-3789. *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. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under this *policy*.

The ID card will show *your* name, member ID#, and *copayment amounts* required at the time of service. If *you* do not get *your* ID card within a few weeks after *you* enroll, please call Member Services at 1-855-650-3789. *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.homestatehealth.com. It also gives *you* information on *your* benefits and services such as:

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

Quality Improvement

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

1. Conducting a thorough check on *health care professionals* 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, preventive health screenings, and immunizations.
4. A Quality Improvement Committee that 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 health care professional* 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.

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

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 provider or *facility* network status with the health plan; or
2. Non-emergency health care services provided to a Member at an in-network hospital or at an in-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 *Policy* 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 *health care professionals*. *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 Health Insurance Marketplace. Advance payments of the tax credit can be used right away to lower *your* monthly premium costs. If *you* qualify, *you* may choose how much advance credit payments to apply to *your* premiums each month, up to the maximum amount. If the amount of advance credit payments *you* get for the year is less than the tax credit *you'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 Determination means a decision by *us* which results in: a determination by a health carrier or a *utilization review entity* that an admission, availability of care, continued stay or other health care service furnished or proposed to be furnished to an enrollee has been reviewed and, based upon the information provided, does not meet the *utilization review entity* or health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or are experimental or investigational, and the payment for the requested service is therefore denied, reduced or terminated. Refer to the Internal *Grievance*, Internal Appeals and External Appeals Procedures section of this *policy* 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.

Alcohol Treatment Facility means a residential or nonresidential *facility* certified by the Missouri Department of Mental Health for *treatment* of alcohol abuse.

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 *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 <https://ambetter.homestatehealth.com/health-plans/our-benefits/ambetter-telehealth.html>.

Appeal means a written *complaint* regarding:

1. Claims payment, handling or reimbursement for health care services or
2. A *complaint* regarding an *adverse determination* made pursuant to *utilization review*;

Applied behavior analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Autism service provider means:

- (a) Any person, entity, or group that provides diagnostic or *treatment* services for *autism spectrum disorders* who is licensed or certified by the state of Missouri; or
- (b) Any person who is licensed under chapter 337 as a board-certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board-certified behavior analyst.

Autism spectrum disorder refers to a neurobiological disorder, an *illness* of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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.

Authorization or Authorized or "Approval" means *our* decision to approve the *medical necessity* or the appropriateness of care for an enrollee.

Authorized representative means an individual who represents a covered person 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.

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

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

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

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

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

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

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

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of transplants or other services such as cancer 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*.

Claim involving urgent care means any claim for *medical care* or *treatment* with respect to the application of the time periods for making non-urgent care determinations.

1. Could seriously jeopardize the life or health of the *claimant* or the ability of the *claimant* to regain maximum function, or,
2. In the opinion of a *health care professional* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or *treatment* is the subject of the claim.

The determination whether a claim is a “*claim involving urgent care*” will be determined by *us*; or, by a *health care professional* with knowledge of the *claimant's* medical condition.

Claimant is the *member* or *member's authorized representative* who has contacted the plan to file a *complaint* or *appeal* or who has contacted the Missouri Department of Commerce and Insurance to file an external review.

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

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

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 but is not limited to: ectopic pregnancy, spontaneous abortion, eclampsia, missed abortion, and similar medical surgical conditions of comparable severity.

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

Concurrent review means *utilization review* conducted during a patient's *hospital* stay or course of treatment.

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

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

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

Cosmetic treatment means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an *injury, illness, or congenital anomaly*. *Cosmetic treatment* does not include *reconstructive surgery* when the service is incidental to or follows *surgery* resulting from trauma, infection or other diseases of the involved part, and *reconstructive surgery* because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect.

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

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

Covered service or covered service expenses means healthcare services, supplies or *treatment* as described in this *policy* which are performed, prescribed, directed or authorized by a *health care professional*. 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 *policy*.

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

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

The *deductible amount* does not include any *copayment amounts*.

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

Dental expenses 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, civil union partner* and/or an *eligible child*, by blood or law, who is under age 26.

Developmental or physical disability means a severe chronic disability that:

- (a) Is attributable to cerebral palsy, epilepsy, or any other condition other than mental *illness* or *autism spectrum disorder* which results in impairment of general intellectual functioning or adaptive behavior and requires *treatment* or services;
- (b) Manifests before the individual reaches age nineteen;
- (c) Is likely to continue indefinitely; and
- (d) Results in substantial functional limitations in three or more of the following areas of major life activities:
 - a. Self-care;
 - b. Understanding and use of language;
 - c. Learning;
 - d. Mobility;
 - e. Self-direction; or
 - f. Capacity for independent living

Diagnosis means *medically necessary* assessments, evaluations, or tests in order to diagnose whether an individual has an *autism spectrum disorder* or a *developmental or physical disability*.

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

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

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

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption; or
4. A child for whom legal guardianship has been awarded to *you* or *your spouse*.

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

Eligible service expense or eligible expense means a *covered service* 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 Missouri law, the *eligible service expense* is as follows:
 - a. When a *covered service* is received from a *non-network provider* within a *network facility* 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. However, if the provider has not agreed to accept a negotiated fee with *us* as payment in full, the *eligible expense* is a reasonable reimbursement based upon the healthcare professional *provider's* services. *You* will not be billed for the difference between the amount *we* pay and the provider's charge but *you* will be subject to *cost-sharing* based upon the reimbursement amount. 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 facility* or from a *non-network provider* at a *non-network facility* 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. However, if the *provider* has not agreed to accept a negotiated fee with *us* as payment in full, unless otherwise required by federal or Missouri law, the *eligible expense* is a reasonable reimbursement as determined by *us*. *You* will not be billed for the difference between the amount *we* pay and the *provider's* charge but *you* will be subject to *cost-sharing* based upon the qualifying payment amount. If *you* are balance billed in these situations, please contact Member Services immediately at the number listed on the back of *your* ID card.
 - c. When a *covered service* is received from a *non-network provider* within a *network hospital* or a *network ambulatory surgical center* not 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. However, if the provider has not agreed to accept a negotiated fee with *us* as payment in full, unless otherwise required by federal or Missouri law, the *eligible expense* is a reasonable reimbursement as determined by *us*. Unless *you* receive and sign the necessary written notice and consent document under federal law before the services are provided, *you* will not be billed for the difference between the amount *we* pay and the provider's charge but *you* will be subject to cost-sharing based upon the qualifying payment amount. If *you* are balance billed in these situations, please contact Member Services immediately at the number listed on the back of *your* ID card.
 - d. 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 medical condition means the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate *medical care* is required, which may include, but shall not be limited to:

- (a) Placing the person's health in significant jeopardy;
- (b) Serious impairment to a bodily function;
- (c) Serious dysfunction of any bodily organ or part;
- (d) Inadequately controlled pain; or
- (e) With respect to a pregnant woman who is having contractions:
 - a. That there is inadequate time to effect a safe transfer to another *hospital* before delivery; or
 - b. That transfer to another *hospital* may pose a threat to the health or safety of the woman or 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 are defined by federal law and refer to benefits in at least the following categories: Ambulatory patient services, *Emergency services*, Hospitalization, Maternity and newborn care, Mental health and *substance use disorder* services, including *behavioral health* treatment, Prescription drugs, Rehabilitative and habilitative services and devices, Laboratory services, Preventive and wellness services, and chronic disease management and pediatric services, including oral and vision care. *Essential health benefits* provided within this *policy* are not subject to lifetime or annual dollar maximums.

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. 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;

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

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

Facility means any medical or *behavioral health* services organization that allows individuals to be treated on an inpatient or outpatient basis. This includes but is not limited to *extended care facilities*, *alcoholism treatment facilities*, *surgical facilities*, *habilitation and rehabilitation facilities*, and *hospitals*.

Final adverse benefit determination means an adverse benefit determination that is upheld at the completion of *our* internal *appeals* process.

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

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

Grievance means a written *complaint* submitted by or on behalf of an enrollee regarding the:

- 1) Availability, delivery or quality of health care services, including a *complaint* regarding an *adverse determination* made pursuant to *utilization review*;
- 2) Claims payment, handling or reimbursement for health care services; or

3) Matters pertaining to the contractual relationship between an enrollee and a health carrier.

Habilitative or rehabilitative care for individuals with autism spectrum disorder means professional, counseling, and guidance services and *treatment* programs, including *applied behavior analysis* for those diagnosed with *autism spectrum disorder*, that are necessary to develop the functioning of an individual.

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

Health care provider or provider means a *health care professional* or *facility*.

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

Hearing instrument or hearing aid means any instrument or device designed, intended, or offered for the purpose of improving a person's hearing and any parts, attachments, or accessories, including ear molds. Batteries, cords, and individual or group auditory training devices and any instrument or device used by a public utility in providing telephone or other communication services are excluded.

Hearing instrument dispenser means a person who is a *hearing care professional* that engages in the selling, practice of fitting, selecting, recommending, dispensing, or servicing of hearing instruments or the testing for means of *hearing instrument* selection or who advertises or displays a sign or represents himself or herself as a person who practices the testing, fitting, selecting, servicing, dispensing, or selling of hearing instruments.

Hearing loss, also referred to as loss or impairment of speech or hearing, includes those communicative disorders generally treated by a speech pathologist, audiologist or speech/language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both, and which fall within the scope of his or her license or certification.

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 *health care professional*

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 *health care*

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

Hospice refers to services designed for and provided to *members* who are not expected to live for more than 12 months, as certified by *your health care professional* and the *hospice medical director*. Ambetter works with certified *hospice* programs licensed by the state to minimize patient discomfort and address the special physical, psychological, and social needs of *terminally ill members* and their immediate family.

Hospital means an institution that:

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

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

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

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

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

Injury means accidental bodily damage sustained by a *member* that is the direct cause of the condition for which benefits are provided, independent of disease or body infirmity or any other cause that occurs while this *contract* is in force. All *injuries* due to the same accident are deemed to be one *injury*.

Inpatient means that services, supplies, or *treatment* for medical, *behavioral health* and substance 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 that part of a *hospital* service specifically designed as an *intensive care unit* permanently equipped and staffed to provide more extensive care for critically ill or injured patients than

available in other *hospital* rooms or wards, the care to include close observation by trained and qualified personnel whose duties are primarily confined to the part of the *hospital* for which an additional charge is made.

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.

Language assistance means translation services provided if requested. Contact customer service at 1-855-650-3789 if oral or written services are needed.

1. We must provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and *appeals* (including external review) in any applicable non-English language;
2. We must provide, upon request, a notice in any applicable non-English language; and
3. We must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan or issuer.

Applicable non-English language. With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary of Health and Human Services.

Line therapist means an individual who provides supervision of an individual diagnosed with an autism *diagnosis* and other neurodevelopmental disorders pursuant to the prescribed *treatment* plan, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst.

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

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), however this will not apply to a dependent living outside the *service area* if a court order requires the *member* to cover the dependent ;

3. In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a *service area*, loss of coverage because an individual no longer resides, lives, or works in the *service area* (whether or not within the choice of the individual), and no other benefit package is available to the individual;
4. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in 26 CFR § 54.9802-1(d)) that includes the individual.
5. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.
6. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

Mammography means, for purposes of this *policy*, the X-ray examination of the breast using equipment specifically designed and dedicated for mammography, including the X-ray tube, filter, compression device, detector, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast, and any fee charged by a radiologist or other *physician* for reading, interpreting or diagnosing based on such X-ray. As used in this section, the term "low-dose *mammography* screening" shall also include digital *mammography* and breast tomosynthesis. As used in this section, the term "breast tomosynthesis" shall mean a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

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

Manipulative Therapy means *treatment* applied to the spine or joint structures to correct vertebral or joint malposition and to eliminate or alleviate somatic dysfunction including, but not limited to, manipulation, myofascial release or soft tissue mobilization. *Treatment* must demonstrate pain relief and continued improvement in range of motion and function and cannot be performed for maintenance care only. *Manipulative therapy* is not limited to *treatment* by manual means.

Maximum out-of-pocket amount is the sum of the *deductible amount*, *prescription drug deductible amount* (if applicable), and *copayment amount* and *coinsurance* percentage of *covered service 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 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 one or more covered persons' *eligible expenses*. A covered person's *maximum out-of-pocket* will not exceed the individual *maximum out-of-pocket amount*.

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

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

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

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

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

Medical practitioner includes but is not limited to a *physician*, nurse anesthetist, *physician's* assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *contract*: rolfer, hypnotist, 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, based on our determination, any medical service, items, supply or *treatment* to diagnose and treat a *member's illness or injury*:

1. Is consistent with the symptoms or *diagnosis*;
2. Is provided according to *generally accepted standards of medical practice*;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *health care professional* or the *member*;
5. Is not *experimental or investigational*;
6. 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
7. 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, nor is any material deterioration of the condition likely to occur before an individual may be transferred. 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 or **Covered Person** means an individual covered by the health plan including an enrollee, subscriber or *policy* holder.

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 or the current edition of the International Classification of Diseases..

Necessary medical supplies mean medical supplies that are:

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

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

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

Network provider means any person or entity that has entered into a *contract* with Ambetter from Home State Health to provide *covered services* to members enrolled under this *policy* including but not limited to, hospitals, specialty hospitals, urgent care facilities, physicians, pharmacies, laboratories and other health professionals within our *service area*.

Non-elective caesarean section means:

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

Non-network provider means a *healthcare professional*, *provider*, or *provider facility* who is NOT identified in the most current list for the *network* shown on *your* identification card. Services received from a *non-network provider* are not covered, except as specifically stated in this *policy*.

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 *policy*.

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

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

Other Practitioner 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 *health care professional* or other professional.

Outpatient Contraceptive Services means consultations, examinations, and medical services, provided on an *outpatient* basis and related to the use of contraceptive methods to prevent *pregnancy* which has been approved by the U.S. Food and Drug Administration.

Outpatient surgical facility means any *facility* with a medical staff of *health care professionals* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This includes ambulatory surgical centers. This does not include facilities such as: acute-care clinics, *urgent care centers*, ambulatory-care clinics, free-standing *emergency* facilities, and *health care professional* 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 health care system. A *pain management program* must be individualized and provide physical *rehabilitation*, education on pain, relaxation training, and medical evaluation.

Pharmacy care means medications used to address symptoms of an *autism spectrum disorder* or a *developmental or physical disability* prescribed by a licensed physician, and any health-related services deemed *medically necessary* to determine the need or effectiveness of the medications only to the extent that such medications are included in the insured's health benefit plan.

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 a benefit under this *contract* that has already been provided.

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

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 service 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 *member* 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 *member's eligible expenses*.

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

Primary care provider 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 certification made pursuant to a *prior authorization* review, or notice as required by a health carrier or *utilization review entity* prior to the provision of health care services

Prior authorization review means a *utilization review* conducted prior to an admission or a course of treatment, including but not limited to pre-admission review, *pretreatment* review, *utilization review*, and case management

Proof of loss means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, medical bills or records, other plan information, 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 see definition for *health care provider*

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

Psychiatric care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Psychological care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices

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 (QHP)* in the individual market.

Rescission means a cancellation or discontinuance of coverage that has a retroactive effect. "Rescission" does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage

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 type of care must be *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 medical practitioner means a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation 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.

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

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.

Retrospective review means *utilization review* of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

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.

Scalp hair prostheses means artificial substitutes for scalp hair that are made specifically for a specific *member*.

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

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

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

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 health care professional is a *health care professional 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 practitioners* and performed for one-half hour to two 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*.

Substance use disorder means the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both. Covered *substance use disorders* are those listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

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 *health care professional* 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 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 *health care professional* has given a prognosis that a *member* has 12 months or less to live.

Therapeutic care means services provided by licensed speech therapists, occupational therapists, or physical therapists.

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 *member* or an insured *dependent member* 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 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.

Treatment means care prescribed or ordered for an individual diagnosed with an *autism spectrum disorder* by a licensed *health care professional* or licensed psychologist, or for an individual diagnosed with a *developmental or physical disability* by a licensed *physician* or licensed psychologist, including equipment *medically necessary* for such care, pursuant to the powers granted under such licensed *health care professional's* or licensed psychologist's license, including, but not limited to:

- (a) *Psychiatric care*;
- (b) *Psychological care*;
- (c) *Habilitative or rehabilitative care*, including *applied behavior analysis* therapy;
- (d) *Therapeutic care*;
- (e) *Pharmacy care*.

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

1. "*Well-conducted randomized controlled trials*" means that two or more treatments are

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

Urgent care center means a *facility*, not including a *hospital emergency room* or a *health care professional'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 set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, *prior authorization* review, second opinion, certification, *concurrent review*, *care management*, discharge planning or *retrospective review*. *Utilization review* shall not include elective requests for clarification of coverage.

Utilization review entity refers to Ambetter, as this is the entity that will perform *prior authorization* reviews for requested services.

DEPENDENT MEMBER COVERAGE

Dependent Eligibility

Your dependent members become eligible for insurance 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 a *covered person* for the purposes of adoption or a *covered person* assumes total or partial financial support of the child.

Effective Date for Initial Dependents

The *effective date* for *your* initial *dependents*, if any, 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 a *covered person* will be covered from the time of birth until the 31st day after its birth. Each type of *covered service* incurred by the newborn child will be subject to the *cost sharing* amount listed in the *Schedule of Benefits*.

The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and *treatment* of medically diagnosed congenital defects and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth. If notice of the newborn is given to *us* by the Health Insurance Marketplace within the 31 days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 days after the birth of the child. If notice is given by the Health Insurance Marketplace within 60 days of the birth of the child, the *contract* may not deny coverage of the child due to failure to notify *us* of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st day after its birth, unless *we* have received notice from the entity that *you* have enrolled (either the Health Insurance Marketplace or *us*). If *you* have requested enrollment application materials from *us*, *we* will allow up to 10 additional days of coverage after the original 31 days of coverage in order for *you* to complete the forms and submit them to *us*.

Coverage for an Adopted Child

An *eligible child* legally placed for adoption with a *covered person* will be covered from the date of birth if a petition for adoption is filed within 31 days of the birth of such child, or 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 on the same basis as any other dependent. Coverage shall include the necessary care and *treatment* of medical 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 date that *you* or *your spouse* assume physical custody of the child

for the purpose of adoption pursuant to an adoption proceeding.

Adding Other Dependents

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

Coverage for a Member Confined to an Inpatient Hospital

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

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

ONGOING ELIGIBILITY

For All Members

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

1. The date of a *member's* death;
2. 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*;
3. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or
4. The date of termination that the Health Insurance Marketplace provides us upon *your* request of cancellation to the Health Insurance Marketplace, or if *you* enrolled directly with us, the date *we* receive a request from *you* to terminate this *contract*, or any later date stated in *your* request.

If *you* have material modifications (examples include a change in life event (marriage, death) or family status), or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace at www.healthcare.gov or 1-800-318-2596. If *you* enrolled through Ambetter contact Member Services Department: 855-650-3789 TDD/TTY 711.

For Dependent Members

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

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

1. Incapable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit was reached; and
2. Mainly *dependent* on the primary *member* for support.

Open Enrollment

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

Special Enrollment Period

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

1. A *qualified individual* or *dependent* loses minimum essential coverage, non-calendar year group or individual health insurance coverage, pregnancy-related coverage, access to healthcare services through coverage provided to a pregnant enrollee’s unborn child, or medically needed coverage;
2. A *qualified individual* gains a *dependent* or becomes a *dependent* through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order. In the case of marriage, at least one *spouse* must demonstrate having minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage;

3. A *qualified individual* or *dependent*, who was not previously a citizen, national, or lawfully present individual gains such status; or who is no longer incarcerated or whose incarceration is pending the disposition of charges;
4. A *qualified individual's* enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or its instrumentalities as evaluated and are determined by the Health Insurance Marketplace;
5. An enrollee or *dependent* adequately demonstrates to the Health Insurance Marketplace that the plan in which he or she is enrolled substantially violated a material provision of its *contract* in relation to the enrollee;
6. A *qualified individual*, enrollee, or *dependent*, adequately demonstrates to the Health Insurance Marketplace that a material error related to plan benefits, *service area*, or premium influenced the qualified individual's or enrollee's decision to purchase the QHP;
7. An enrollee or *dependent* enrolled in the same plan is determined newly eligible or newly ineligible for *advanced premium tax credits* or has a change in *eligibility* for *cost-sharing reductions*;
8. A *qualified individual* or *dependent* who is enrolled in an eligible employer-sponsored plan is determined newly eligible for *advanced premium tax credits* based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-2(c)(3);
9. A *qualified individual*, enrollee, or *dependent* gains access to new QHPs as a result of a permanent move, and had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for one or more days during the sixty days preceding the date of the permanent move;
10. A *qualified individual* or *dependent* who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a plan or change from one plan to another one time per month;
11. A *qualified individual* or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide;
12. A *qualified individual*, enrollee, or *dependent* is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B-2, and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
13. A *qualified individual* or *dependent* is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 days after the qualifying event; or applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;
14. A *qualified individual* newly gains access to an employer sponsored Individual Coverage Health Reimbursement Arrangement (ICHRA) (as defined in 45 CFR 146.123(b)) or a Qualified Small Employer Health Reimbursement Arrangement (QSHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code);
15. At the option of the Health Insurance Marketplace, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a plan through the Health Insurance Marketplace following termination of enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence; or
16. A *qualified individual* or *dependent* is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions or government subsidies completely cease.

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

If *you* are currently enrolled in Ambetter from Home State Health, please contact Member Services at 1-855-650-3789 TDD/TTY 711 with any questions related to *your* health insurance coverage

Coverage Effective Dates for Special Enrollment Periods

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

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

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 3 months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if advance premium tax credits are received.

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

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

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

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

Similarly, if *we* determine payment was made for deductibles or *cost sharing* by a *third party*, such as a drug manufacturer paying for all or part of a medication, that shall be considered a *third party* premium payment

that may not be counted towards *your* deductible or *maximum out-of-pocket* costs.

Reinstatement

If *you* have coverage purchased outside the Health Insurance Marketplace, and *your contract* lapses due to nonpayment of premium, it may be reinstated provided:

1. We receive from *you* a written application for reinstatement within one year after the date coverage lapsed; and
2. The written application for reinstatement is accompanied by the required premium payment.

Premium accepted for reinstatement may be applied to a period for which premium had not been paid. The period for which back premium may be required will not begin more than 60 days before the date of reinstatement.

The *Rescissions* provision will apply to statements made on the reinstatement application, based on the date of reinstatement. For coverage purchased via the Health Insurance Marketplace, the Health Insurance Marketplace should be contacted for reinstatement.

In all other respects, *you* and *we* will have the same rights as before *your contract* lapsed.

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 the Health Insurance Marketplace of *your new residence* within 60 days of the change. As a result *your* premium may change and *you* may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information.

Misstatement of Tobacco or Nicotine Use

The answer to the *tobacco or nicotine* question on the application is material to *our* correct underwriting. If a *member's use of tobacco or nicotine* has been misstated on the *member's* application for coverage under this *contract*, we have the right to reate 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* will 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 *policy*. All benefits we pay will be subject to all conditions, limitations, and *cost sharing* features of this *policy*. *Cost sharing* means that you participate or share in the cost of your healthcare services by paying *deductible amounts*, *copayments* and *coinsurance* for some *covered services*. For example, you may need to pay a *deductible*, *copayment* or *coinsurance* amount when you visit your *health care professional* or are admitted into the hospital. The *copayment* or *coinsurance* required for each type of service as well as your *deductible* is listed in your *schedule of benefits*.

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

Copayments

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

Coinsurance Percentage

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

Deductible

The *deductible amount* means the amount of *covered service expenses* that must be paid by all *members* before any benefits are payable. If on a family plan, if one *member* of the family meets his or her *deductible*, benefits for that *member* will be paid. 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 payable will be subject to:

1. Any specific benefit limits stated in the *contract*;
2. A determination of *eligible expenses*; and
3. Any reduction for expenses incurred at a *non-network provider*. Please refer to the information on the *schedule of benefits*.

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

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

The amount provided or payable will be subject to:

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

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

ACCESS TO CARE

Primary Care Provider

You may designate a *primary care provider* for each *member*. You may select any *network primary care provider* who is accepting new patients. 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 *health care professional* types:

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

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

You may obtain a list of *network primary care providers* at our website and using the "Find a Provider" function or by calling the telephone number shown on the front page of this *policy*.

Changing Your Primary Care Provider (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.homestatehealth.com, or by contacting our office at the number shown on your identification card. The change to your *network primary care provider* of record will be effective no later than 30 days from the date we receive your request.

Contacting Your Primary Care Provider

To make an appointment with your *primary care provider*, call their 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 *primary care provider's* office hours, you should call your *primary care provider'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 *primary care provider* during normal office hours, call our 24/7 nurse advice line at 1-855-650-3789 (TDD/TTY 711). A licensed nurse is always available and ready to answer your health questions. In an emergency, call 911 or head straight to the nearest emergency room.

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.

Coverage under Other Contract Provisions

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

Non-Emergency Services

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

New Technology

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

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

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

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

MEDICAL EXPENSE BENEFITS

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

Copayments, deductibles, and coinsurance amounts must be paid to *your* network provider at the time *you* receive services.

All *covered services* are subject to conditions, exclusions, limitations, terms and provision of this *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, 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 case 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* 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.

Please note: Unless otherwise required by Federal or Missouri law, if *you* receive services from *non-network ambulance providers*, *you* may be responsible for costs above the allowed charges.

Exclusions:

No benefits will be paid for:

1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-emergency air ambulance.
3. Ambulance services provided for a *member's* comfort or convenience.
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 from Home State Health Plan.
4. When ordered by an employer, school, fire or public safety official and the member is not in a position to refuse; or
5. When a member is required by us to move from a non-network provider to a network provider.

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

Limitations: Benefits for air ambulance services are limited to:

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

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

Exclusions:

No benefits will be paid for:

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

Autism Spectrum Disorder Expense Benefit

Covered service expenses for autism spectrum disorder and developmental or physical disabilities include coverage for the diagnosis of autism spectrum disorders and developmental or physical disabilities and for the treatment of autism spectrum disorders and developmental or physical disabilities.

Coverage provided under this section for *autism spectrum disorder* or developmental or physical disabilities is limited to *medically necessary treatment* that is ordered by the insured's treating licensed *physician* or licensed psychologist, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, in accordance with a *treatment plan*

The *treatment plan*, upon request by the health benefit plan or health carrier, shall include all elements necessary for the health benefit plan or health carrier to pay claims. Such elements include, but are not limited to, a *diagnosis*, proposed *treatment* by type, frequency and duration of *treatment*, and goals.

Except for inpatient services, if an individual is receiving *treatment* for an *autism spectrum disorder* or *developmental or physical disability*, a health carrier shall have the right to review the *treatment plan* not more than once every six months unless the health carrier and the individual's treating *physician* or psychologist agree that a more frequent review is necessary. Any such agreement regarding the right

to review a *treatment* plan more frequently shall only apply to a particular individual receiving *applied behavior analysis* and shall not apply to all individuals receiving *applied behavior analysis* from that *autism service provider*, physician, or psychologist. The cost of obtaining any review or *treatment* plan shall be borne by the health benefit plan or health carrier, as applicable.

1. Upon request by us, a *provider of treatment for autism spectrum disorders* shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical *treatment* is *medically necessary* and is resulting in improved clinical status. When *treatment* is anticipated to require continued services to achieve demonstrable progress, we may request a *treatment* plan consisting of *diagnosis*, proposed *treatment* by type, frequency, anticipated duration of *treatment*, the anticipated outcomes stated as goals, and the frequency by which the *treatment* plan will be updated.
2. When making a determination of medical necessity for a *treatment* modality for *autism spectrum disorders*, we will make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under this *contract*, including an *appeals* process. During the *appeals* process, any challenge to *medical necessity* must be viewed as reasonable only if the review includes a *health care professional* with expertise in the most current and effective *treatment* modalities for *autism spectrum disorders*. Coverage for *medically necessary* early intervention services must be delivered by certified early intervention specialists.
3. *Habilitation and Rehabilitation services*, for members with a *diagnosis* of *autism spectrum disorder*, shall include: *applied behavior analysis* that is intended to develop, maintain, and restore the functioning of an individual. For physical therapy, speech therapy, or occupational therapy, there is no visit limit when used for the *treatment* of *Autism Spectrum Disorders*.

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

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

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

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

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

Clinical trials can be approved if they are approved or funded by one of the following:

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. A cooperative group or center of any of the entities listed above or the Department of Defense or the Department of Veteran Affairs;
6. The FDA in the form of an investigational new drug application;
7. The study or investigation is a drug trial that is exempt from having such an investigational new drug application
8. The federal Departments of Veterans' Affairs, Defense, or Energy;
9. 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;
10. A qualified non-governmental research entity that meets the criteria for NIH Center support grant eligibility;

In a clinical trial, the treating *facility* and personnel must have the expertise and training to provide the *treatment* and treat a sufficient volume of patients. A *qualified individual* must be eligible to participate in the clinical trial, and either (a) have a referral from a doctor stating that the clinical trial would be appropriate for the purposes of prevention, early detection, or *treatment* of cancer or a life-threatening disease or condition; or (b) the individual must provide medical and scientific information establishing that their participation in the clinical trial would serve the purposes of prevention, early detection, or *treatment* of cancer or a life-threatening disease or condition.

Providers participating in clinical trials shall obtain a patient's informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards. Such documents shall be made available to *us* upon request.

The coverage required by this section is subject to the standard *contract* provisions applicable to other benefits, including *deductible* and *coinsurance*.

Vision Benefits – Adults 19 years of age or older

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

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

2. Frames
3. Prescription lenses
 - a. Single;
 - b. Bifocal;
 - c. Trifocal;
 - d. Lenticular; or
 - e. Contact lenses (in lieu of glasses).

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

Services not covered:

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

For additional information about covered vision services, participating vision vendor providers, call Member Services at 1-855-650-3789.

Dental Benefits – Adults 19 years of age or older

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

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

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

Services not covered:

1. Out of network services;
2. Dental services that are not necessary or specifically covered;
3. Hospitalization or other *facility* charges;
4. Prescription drugs dispensed in the dental office;
5. Any dental procedure performed solely as a cosmetic procedure;

6. Charges for dental procedures completed prior to the member's *effective date* of coverage;
7. Services provided by an anesthesiologist;
8. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (wear), realignment of teeth, periodontal splinting, and gnathologic recordings;
9. Direct diagnostic surgical or non-surgical *treatment* procedures applied to jaw joints or muscles;
10. Any artificial material implanted or grafted into soft tissue or bone, surgical removal of implants, and implant-related services;
11. Sinus augmentation;
12. Surgical appliance removal;
13. Intraoral placement of a fixation device;
14. Oral hygiene instruction, tobacco or nicotine counseling, nutritional counseling, or high-risk substance abuse counseling;
15. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture;
16. Any oral *surgery* that includes surgical endodontics (apicoectomy and retrograde filling);
17. Analgesia (nitrous oxide);
18. Removable unilateral dentures;
19. Temporary procedures;
20. Splinting;
21. Oral pathology laboratory charges;
22. Consultations by the treating provider and office visits;
23. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
24. Veneers (bonding of coverings to the teeth);
25. Orthodontic *treatment* procedures;
26. Orthognathic *surgery*;
27. Athletic mouth guards; and,
28. Space maintainers,
29. Dental procedures or restorations to alter or increase vertical dimension of occlusion; and,
30. Dental procedures or restorations to restore or repair loss of tooth structure caused by abrasion, abfraction, or erosion.

Other Dental Services

Anesthesia and *hospital* charges for dental care, for a *member* less than 19 years of age or a *member* who is physically or mentally disabled, are covered if the *member* requires dental *treatment* to be given in a *hospital* or outpatient ambulatory surgical *facility*. The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the *member's* condition under general anesthesia.

Coverage is also provided for:

1. For *medically necessary* oral *surgery*, including the following:
 - a. *Treatment* of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
 - b. Orthognathic *surgery* for a physical abnormality that prevents normal function of the upper and/or lower jaw bone and is *medically necessary* to attain functional capacity of the affected part.
 - c. Oral/surgical correction of accidental injuries as indicated in the "Dental Services" section.
 - d. *Treatment* for Temporomandibular Joint Disorder (TMJ), including removable appliances for TMJ repositioning and related *surgery*, medical care, and diagnostic services.
 - e. *Treatment* of non-dental lesions, such as removal of tumors and biopsies.
 - f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

- g. Surgical procedures that are *medically necessary* to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.
 - h. *Reconstructive surgery* to correct significant deformities caused by congenital or developmental abnormalities, *illness, injury* or an earlier *treatment* in order to create a more normal appearance.
2. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* or office charges for dental care, rendered by a dentist, regardless of whether the services are provided in a participating hospital, surgical center or office, provided to the following *members*:
 - a. A *member* under the age of 19;
 - b. a person who is severely disabled; or
 - c. a person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.
 3. For *dental service expenses* when a *member* suffers an *injury*, that results in:
 - a. Damage to his or her natural teeth;
 - b. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
 4. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, or malocclusions.

Diabetic Care

Benefits are available for *medically necessary* services and supplies used in the *treatment* of persons with gestational, type I or type II 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.

Dialysis Services

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

Covered expenses include:

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

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

Durable Medical Equipment, Prosthetics, and Orthotic Devices

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

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

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

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

Benefits for repairs and replacement do not include the following:

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

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

Durable Medical Equipment

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

Covered services may include, but are not limited to:

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

8. Augmentive communication devices are covered when *we* approve based on the *member's* condition.

Exclusions:

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

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

Medical and surgical supplies

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

Covered services may include, but are not limited to:

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

Exclusions:

Non-covered services include but are not limited to:

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

Prosthetics

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

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

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

Covered services may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular

replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.

2. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and *four* surgical bras per benefit period, as required by the Women's Health and Cancer Rights Act. Maximums for prosthetic devices, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the *treatment* of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are *Covered Services*. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract *surgery* or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of *surgery* are not considered contact lenses, and are not considered the first lens following surgery. If the *injury* is to one eye or if cataracts are removed from only one eye and the *member* selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (the first one following cancer *treatment*, not to exceed one per benefit period) when purchased through a health plan DME 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*) when purchased through other than a health plan DME provider.

Orthotic devices

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

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

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

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

Covered service expenses include 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 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; and
 - c. Drugs and medicines that are prescribed by a *health care professional*, filled by a licensed pharmacist, and approved by the U.S. Food and Drug Administration;
4. Covered service expenses for non-provider facility services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners*.
5. Coverage for a Skilled Nursing Facility and inpatient *rehabilitation* is limited to 150 days per year.
6. *Habilitation* Services are limited to 20 visits per year for Occupational Therapy and Physical Therapy. There is not a visit limit for Speech Therapy or Autism Services.
7. *Rehabilitation* Services are limited to 20 visits per year for Occupational Therapy and Physical Therapy. There is not a visit limit for Speech Therapy or Autism services.
8. Coverage for Cardiac *Rehabilitation*.

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; and
4. Care is primarily *custodial care*.

Definition:

As used in this provision, "*provider facility*" means a *hospital*, *rehabilitation facility*, or *extended care facility*.

Hearing and Communicative Disorders

Necessary care and *treatment* shall include services to identify, assess, diagnose and consult about the need for *treatment* and to evaluate and monitor the effectiveness of *treatment* whether by instrumental, perceptual or standard procedures as well as the provision of *treatment* for any of the previously

mentioned communicative disorders. These services shall include, but not be limited to:

- 1) Diagnostic and extended evaluation of hearing, which may include pure tone air conduction thresholds, speech thresholds, bone conduction thresholds, prediction of *hearing loss* from acoustic reflex, reflex eliciting auditory test, communication handicap inventories, word/sentence recognition tests and evoked potential monitoring and testing;
- 2) Determining range, nature and degree of hearing function related to a patient's auditory efficiency;
- 3) Comprehensive behavioral evaluation for sensorineural site which includes advanced acoustic reflex tests, tests of auditory adaptation, tests of frequency discrimination and tests of intensity discrimination;
- 4) Testing, adjusting and evaluating auditory prosthetic devices which may include sound field tests, such as aided word/sentence recognition, real ear measures, warble tone thresholds, narrow band noise thresholds, and comfortable and uncomfortable loudness levels while wearing an auditory prosthesis;
- 5) Differentiation between organic and nonorganic hearing disabilities through evaluation of total response pattern and use of acoustic tests;
- 6) Planning, directing, conducting or participating in conservation, habilitative and rehabilitative programs including *hearing aid* selection and orientation, counseling, guidance, auditory training, speech reading, language *habilitation* and speech conservation;
- 7) Coordinating and consulting with educational, medical and other professional groups, and with patients and their families;
- 8) Diagnosing and evaluating speech and language competencies of individuals, including assessment of speech and language skills as related to educational, medical, developmental, social and psychological factors;
- 9) The services enumerated in paragraphs (2)(B)1.-8 shall be designed to evaluate and treat individuals to develop or utilize speech, language and other communicative skills to the maximum extent possible to remedy any loss or impairment for which services are being provided. However, nothing in this rule shall be construed to require services to improve public speaking, care of the professional voice or accent reduction;
- 10) Cognitive training secondary to open or closed head injury, regardless of cause;
- 11) Assisting individuals with voice disorders to develop proper control of the vocal and respiratory systems for correct voice production;
- 12) Evaluating and treating children with delayed or impaired speech or language disorders;
- 13) Determining the need for augmentative/prosthetic communication systems whether or not that system or that device replaces a body part. These systems or devices may include, but are not limited to, sign language, gesture systems, communication boards, electronic automated devices, mechanical devices, alaryngeal prosthesis, palatal prosthesis and synthetic voice systems; and
- 14) Planning, directing, or conducting habilitative and rehabilitative *treatment* programs to restore or provide communicative efficiency to individuals with communication problems of organic and nonorganic etiology, such as partial to total glossectomy, partial to total laryngectomy, or both; and
 - a. Other *covered services* shall mean any other *medically necessary* medical or health care services, or both, for which coverage is provided whether or not for acute conditions, provided while a patient in a hospital, or provided by or in a *rehabilitation center*, skilled nursing *facility*, clinic, home health agency or community-based program. This means that limitations on coverage may not be specific to speech, language and hearing disorders or for services rendered by speech language pathologists and audiologists.
 - b. The communicative disorders generally treated by speech/language pathologists and audiologists shall include, but not be limited to, aphasia; motor speech disorders; delayed speech or language ability; total or partial speech or language loss or deficit; swallowing disorders; total or partial *hearing loss* or deficit; disorders of verbal and written language, articulation, voice, fluency, mastication, deglutition, cognition, auditory or visual processing and memory, and interactive communications; and disorders of air conduction, bone conduction, word/sentence recognition and acoustic impedance.

Hearing Aids

One pair of hearing aids is covered each year, regardless of *member's* age. 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*.

Home Health Care Service Expense Benefits

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

1. *Home health aide services*;
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care*;
3. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to your *schedule of benefits* for any limits associated with this benefit.
4. I.V. medication and pain medication;
5. Hemodialysis, and for the processing and administration of blood or blood components;
6. *Medically necessary medical supplies*;
7. Rental of *medically necessary durable medical equipment*; and
8. Sleep studies.

I.V. medication and pain medication are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay. At our option, we may *authorize* the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider we *authorize* before the purchase. 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.

Exclusion:

No benefits will be payable for charges related to *respite care*, *custodial care*, or educational care under the Home Healthcare Expense Benefits.

Hospice Care Service Expense Benefits

This provision only applies to a *terminally ill member* receiving *medically necessary* care under a *hospice care program*. *Covered services* include:

The list of *covered service expenses* is expanded to 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 member* 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.

Benefits for *hospice inpatient*, home or *outpatient* care are available to a *terminally ill member* for one continuous period up to 365 days per benefit period. For each day the *member* is confined in a *hospice*, benefits for room and board will not exceed the most common semiprivate room rate of the *hospital* or nursing home with which the *hospice* is associated.

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.

Respite Care Expense Benefits

Respite care is covered on an *inpatient* or *home basis* to allow temporary relief to family members from the duties of caring for a *member* who is undergoing *hospice* care. Respite days that are applied toward the member's cost share obligations 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. A private *hospital* room when needed for isolation.
3. Daily room and board and nursing services while confined in an *intensive care unit*.
4. *Inpatient* use of an operating, *treatment*, or recovery room.
5. *Outpatient* use of an operating, *treatment*, or recovery room for *surgery*.
6. Services and supplies, including drugs and medicines, which are routinely provided by the *hospital* for use only while *you* are *inpatient*.
7. *Emergency treatment* of an *injury* or *illness*, even if confinement is not required. See *your schedule of benefits* for limitations.

Radiology, Imaging and Other Diagnostic Testing

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

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*.

Infertility Services

Covered services for infertility *treatment* are limited to diagnostic testing to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy and semen analysis. Benefits are included to treat the

underlying medical conditions that cause infertility (such as endometriosis, obstructed fallopian tubes and hormone deficiency).

Mammography Coverage

“Mammogram” includes low-dose *mammography* screening, digital *mammography* and breast tomosynthesis. The following services are covered.

- (1) A baseline mammogram for women age thirty-five to thirty-nine, inclusive;
- (2) A mammogram every year for women age forty and over;
- (3) A mammogram every year for any woman deemed by a treating *physician* to have an above-average risk for breast cancer in accordance with the American College of Radiology guidelines for breast cancer screening;
- (4) Any additional or supplemental imaging, such as breast magnetic resonance imaging or ultrasound, deemed *medically necessary* by a treating *physician* for proper breast cancer screening or evaluation in accordance with applicable American College of Radiology guidelines; and
- (5) Ultrasound or magnetic resonance imaging services, if determined by a treating *physician* to be *medically necessary* for the screening or evaluation of breast cancer for any woman deemed by the treating *physician* to have an above-average risk for breast cancer in accordance with American College of Radiology guidelines for breast cancer screening.

Mental Health and Substance Use Disorder Benefits

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

Mental health services will be provided on an *inpatient* and *outpatient* basis and include treatable mental disorders. These disorders affect the *member's* ability to cope with the requirements of daily living. If you need mental health and/or *substance use disorder treatment*, you may choose any provider participating in our *behavioral health* network. You can search for in-network *Behavioral Health* providers by using our Find a Provider tool at Ambetter.homestatehealth.com or by calling Member Services at 855-650-3789 (TTY/TDD 711). *Deductible amounts, copayment or coinsurance amounts and treatment limits* for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

Covered services for mental health and *substance use disorder* are included on a non-discriminatory basis for all *members* for the *diagnosis* and *treatment* of mental, emotional, and/or *substance use disorders*, including *autism spectrum disorders* as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

When making coverage determinations, our utilization management staff employ 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. They utilize “Interqual” criteria for mental health determinations and ASAM American Society of Addiction Medicine (ASAM) criteria for *substance use* determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

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

Inpatient

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

Outpatient

1. Partial Hospitalization Program (PHP)
2. Intensive *Outpatient* Program (IOP);
3. *Outpatient* detoxification programs;
4. Evaluation and assessment for mental health and substance use, at least 2 sessions per year. These sessions may be with an out-of-network provider;
5. Individual and group therapy for mental health and substance use;
6. Medication Assisted *Treatment*- combines behavioral therapy and medications to treat *substance use disorders*;
7. Medication management services;
8. Psychological and Neuropsychological testing and assessment;
9. *Applied Behavioral Analysis for treatment of autism*;
10. Mental Health day *treatment*;
11. Telehealth;
12. Electroconvulsive Therapy (ECT); and
13. *Transcranial Magnetic Stimulation (TMS)*.
14. Assertive Community Treatment (ACT)

In addition, *Integrated Care Management* is available for all of *your* healthcare needs, including *behavioral health* and substance use. Please call 855-650-3789 (TTY/TDD 711) to be referred to a care manager for an assessment.

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

Expenses for these services are covered, if *medically necessary* and may be subject to *prior authorization*. Please see the *schedule of benefits* for more information regarding services that require *prior authorization*.

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.

Chiropractic Services

We cover charges for chiropractic services. These services will be covered for a *member* who presents a condition of an orthopedic or neurological nature necessitating *treatment* for which falls within the scope of a licensed chiropractor.

Medical and Surgical Expense Benefits

Medical *covered service expenses* are limited to charges:

1. For *surgery* in a *health care professional's* office or at an *outpatient surgical facility*, including services and supplies.
2. For services received for urgent care, including *facility* charges at an *urgent care center* that is a *network provider*.
3. Made by a *health care professional* for professional services, including *surgery*.
4. Made by an assistant surgeon.
5. For dressings, crutches, orthopedic splints, braces, casts, or other *medically necessary medical supplies*.
6. For diagnostic testing using radiologic, ultrasonographic, or laboratory services.
7. For chemotherapy and radiation therapy or *treatment*.
8. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
9. For the cost and administration of an anesthetic.
10. For oxygen and its administration.
11. For accidental *dental service expenses* when a *member* suffers an *injury*, that results in:
 - a. Damage to his or her natural teeth;
 - b. Expenses are incurred within six months of the accident or as part of a *treatment* plan that was prescribed by a *health care professional* and began within 12 months of the accident to be considered as a *covered service*; and
 - c. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
12. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, or malocclusions.
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 Chiropractic Care, including office visits for assessment, evaluation, spinal adjustment, *medically necessary manipulative therapy treatment* on an *outpatient* basis and physiological therapy before (or in conjunction with) spinal adjustment up to 26 visits per benefit period; visits in excess of 26 will require *prior authorization*
15. For pulse oximetry screening on a newborn.
16. Well Child care examinations for children through the age of 12, including child health supervision services, based on American Academy of Pediatric Guidelines. Refer to Preventive Services for a list of well child/well baby services.
17. For *medically necessary* human organ and tissue transplants.
18. Family Planning for certain professional Provider contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.
19. For *treatment* received outside the United States *while* traveling for up to a maximum of (90) consecutive days.
20. Newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.
21. Allergy testing, injections and serum.
22. For the provision of nonprescription enteral formulas and food products required for *members* with inherited diseases of amino acids and organic acids. Such coverage shall be provided when the

- prescribing *health care professional* has issued a written order stating that the enteral formula or food product is medically necessary. Coverage for inherited diseases of amino acids and organic acids shall, in addition to the enteral formula, include food products modified to be low protein;
23. For scalp hair prosthesis expenses for hair loss suffered as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the *treatment* from any form of cancer or leukemia, or permanent loss of scalp hair due to injury. Such coverage, shall be subject to a written recommendation by the treating *health care professional* stating that the hair prosthesis is a medical necessity;
 24. For children's early intervention therapy for expenses arising from the services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists, and clinical social workers working with children from birth to 36 months of age with an identified developmental disability and/or delay;
 25. For *medically necessary* diagnostic and laboratory and x-ray tests;
 26. Cost for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. Coverage is limited to a maximum cost of \$75 per transplant.
 27. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* charges for dental care, rendered by a dentist, provided to the following *members*:
 - a. a child under the age of five;
 - b. a person who is severely disabled; or
 - c. a person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.
 28. For the *treatment* of breast cancer by dose-intensive chemotherapy/*autologous bone marrow transplants* or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer *treatment* centers experienced in dose-intensive chemotherapy/*autologous bone marrow transplants* or stem cell transplants.
 29. For cancer screenings, as follows:
 - a. A pelvic examination and pap smear for any nonsymptomatic woman who is a *member*, in accordance with the current American Cancer Society guidelines;
 - b. A prostate examination and laboratory tests for cancer for any nonsymptomatic man who is a *member*, in accordance with the current American Cancer Society guidelines; and
 - c. A colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic *member*, in accordance with the current American Cancer Society guidelines.
 30. For telehealth for *covered services* provided within the scope of practice of a *health care professional* or other healthcare provider as a method of delivery of *medical care* by which a *member* shall receive medical services from a healthcare provider without in-person contact with the provider;
 31. For *medically necessary* oral surgery, including the following:
 - a. *Treatment* of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
 - b. Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw bone and is *medically necessary* to attain functional capacity of the affected part.
 - c. Oral / surgical correction of accidental injuries as indicated in the "Dental Services" section.
 - d. *Treatment* for Temporomandibular Joint Disorder (TMJ), including removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services.
 - e. *Treatment* of non-dental lesions, such as removal of tumors and biopsies.
 - f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
 - g. Surgical procedures that are *medically necessary* to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.
 - h. *Reconstructive surgery* to correct significant deformities caused by congenital or developmental abnormalities, *illness, injury* or an earlier *treatment* in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy.
 32. For respiratory and pulmonary therapy;

33. For *medically necessary* genetic blood tests;
34. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV); and
35. Coverage for medically necessary bone mass measurement and for *diagnosis* and *treatment* of osteoporosis.
36. Medically necessary services made by a provider who renders services in an in-network *urgent care center*, including *facility* costs and supplies.

Outpatient Medical Supplies Expense Benefits

Covered service expenses for miscellaneous *outpatient* medical services and 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 *member* 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 service expense*.
2. For one pair of foot orthotics per *member*. Coverage is limited to diabetes care only.
3. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
4. For the cost of one Continuous Passive Motion (CPM) machine per *member* following a covered joint *surgery*.
5. Infusion therapy.
6. For one pair of eyeglasses or contact lenses per *member* following a covered cataract *surgery*.
7. Services related to *diagnosis*, *treatment* and appropriate management of osteoporosis when such services are provided by a person licensed to practice medicine and *surgery* in the state, if the *member* has a condition or medical history for which bone mass measurement is medically indicated.
8. Testing of pregnant women and other *members* for lead poisoning.
9. For any other use of a drug approved by the United States Food and Drug Administration when the drug has not been approved by the United States Food and Drug Administration for the *treatment* of the particular indication for which the drug has been prescribed, provided such drug is recognized for *treatment* of such indication in one of the standard reference compendia or in the medical literature as recommended by current American Medical Association (AMA) policies. Any coverage of a drug required shall also include *medically necessary* services associated with the administration of the drug. This benefit shall not be construed to require:
 - a. Coverage for any drug if the FDA has determined its use to be contraindicated for the *treatment* of the particular indication for which the drug has been prescribed;
 - b. Coverage for experimental or investigational drugs not approved for any indication by the FDA; and
 - c. Reimbursement or coverage for any drug not included on the drug formulary or list of covered drugs specified in this *policy*.

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. *We* do not require that a *health care professional* or other healthcare provider obtain *prior authorization* for the delivery. An inpatient stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require notification to the health plan.

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. *Health care professional* 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.

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

Maternity coverage of a home birth by a midwife or nurse midwife is limited to low risk *pregnancy* and may be subject to *preauthorization* requirements.

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.

Post-Discharge Care

Post-discharge care shall consist of a minimum of two visits at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. The location and schedule of the post-discharge visits shall be determined by the attending physician. Services provided by the registered professional nurse or *physician* shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. Any abnormality, in the condition of the mother or the child, observed by the nurse shall be reported to the attending *physician* as medically appropriate.

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 Limitations 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 from Sunflower Health Plan at the Member Services Department, 11720 Borman Drive, St. Louis, MO 63146. 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

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

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

The level of benefits and out-of-pocket costs for any later part of the 48-hour or 96-hour stay will not be less favorable to the mother or newborn than any earlier part of the stay. *We* do not require that a *health care professional* obtain *authorization* for prescribing a length of stay of up to 48 hours or 96 hours.

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

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 *health care professional*;
3. Off-label drugs that are:
 - a. Recognized for *treatment* of the indication in at least one (1) standard reference compendium; or
 - b. Recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain; and
4. Prescribed, oral anticancer medication;

Covered prescription drugs, which are not subject to utilization management, *prior authorization*, or pre-certification requirements, and are considered maintenance, are covered up-to-90-day supply at retail pharmacies within *our* network. Controlled substances as identified by the United States Drug Enforcement Administration are exempt from this section. The prescription drugs received in a 90-day supply may be subject to co-payments, *coinsurance deductibles*, or other *member* cost shares.

The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her *health care professional*. If *we* change *our* formulary *we* will provide *you* with notification of the change electronically, or in writing, upon *your* request, at least thirty (30) days in advance of the change. If the dosage of a prescription is such that two different manufactured dosage amounts are required, and *you* pay *your copay* for both dosages, *you* may submit the claims to us for reimbursement of the additional *copay*.

Formulary or Prescription Drug List

The formulary or *prescription drug* list is a guide to available generic and brand name drugs, as well as some over-the-counter medications when prescribed 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 or for more information about *our* pharmacy program, visit Ambetter.homestatehealth.com (under "For Member", "Pharmacy Resources") or call Member Services at 855-650-3789 (TDD/TTY 711).

Non-Covered Services and Exclusions:

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

1. For *prescription drug treatment* of erectile dysfunction or any enhancement of sexual performance unless such *treatment* is listed on the formulary.
2. For weight loss prescription drugs unless otherwise listed on the formulary.
3. For immunization agents, blood, or blood plasma, except when used for preventive care and listed on the formulary.
4. For medication that is to be taken by the *member*, in whole or in part, at the place where it is dispensed.
5. For medication received while the *member* is a patient at an institution that has a *facility* for dispensing pharmaceuticals.
6. For a refill dispensed more than 12 months from the date of a *health care professional's* order.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are on the formulary.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program.
11. For more than a 30-day supply when dispensed in any one prescription or refill or for maintenance drugs up to a 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply network. Specialty drugs and other select drug categories are limited to 30-day supply when dispensed by retail or mail order. Please note that only the 90 day supply is subject to the discounted *cost sharing*. Mail orders less than 90 days are subject to the standard *cost sharing* amount;.
12. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
13. Foreign Prescription Medications, except those associated with an *emergency medical condition* while *you* are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this document if obtained in the United States.
14. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventive *treatment* is related to *member's* vacation during out of country travel. This section does not prohibit coverage of *treatment* for aforementioned diseases.
15. For medications used for cosmetic purposes.
16. For infertility drugs unless otherwise listed on the formulary.
17. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.

18. For drugs or dosage amounts determined by Ambetter to be ineffective, unproven or unsafe for the indication for which they have been prescribed, regardless of whether such drugs or dosage amounts have been approved by any governmental regulatory body for that use.
19. For any drug related to dental restorative *treatment* or *treatment* of chronic periodontitis, where drug administration occurs at dental practitioner's office.
20. For any drug dispensed from a non-lock-in pharmacy while *member* is in opioid lock-in program.
21. 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.
22. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.

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 the 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

Standard exception request

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

Expedited exception request

A *member*, a *member's* designee or a *member's* prescribing *health care professional* 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 *health care professional* with *our* coverage determination. Should the standard exception or step therapy protocol exception request be granted, *we* will provide coverage of the non-formulary drug or the drug that is the subject of the protocol exception for the duration of the exigency.

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 *health care professional* may request that the original exception request and subsequent denial of such request be reviewed by an external 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 *health care professional* 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 or step therapy protocol exception request, *we* will provide coverage of the non-formulary drug or the drug that is the subject of the protocol exception for the duration

of the prescription. If we grant an external exception review of an expedited exception request, we will provide coverage of the non-formulary drug or the drug that is the subject of the protocol exception for the duration of the exigency.

Drug discount, Coupon or Copay Card

Cost sharing paid on *your* behalf for any prescription drugs obtained by *you* through the use of a drug discount, coupon, or *copay* card provided by a *prescription drug* manufacturer will not apply toward *your* plan *deductible* or *your* maximum out of pocket.

Lock-In Program

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

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.homestatehealth.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.homestatehealth.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 1-888-624-1139. Alternatively, *you* can fill out an enrollment form and mail the form to the address provided at the bottom of the form. The enrollment form can be found on *our* Ambetter website. Once on *our* website, click on the section, “For Member,” “Pharmacy Resources.” The enrollment form will be located under “Forms.”

Pediatric Vision Benefits – Children under the age of 19

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

1. Routine ophthalmological exam
 - a. Refraction;

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

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

Services not covered:

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

Preventive Care Expense Benefits

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

- 1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. Examples of these services are screenings for cervical cancer and mammography.
- 2. Immunizations for a child from birth to five years of age as provided by department of health and senior services regulations.
- 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 above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.

5. All FDA-approved contraception methods (identified on www.fda.gov) are approved for *members* without *cost sharing* as required under the Affordable Care Act. *Members* have access to the methods available and outlined on *our* Drug Formulary or Preferred Drug List without cost share. Some contraception methods are available through a *member's* medical benefit, including the insertion and removal of the contraceptive device at no cost share to the *member*; and
6. Covers without *cost sharing*:
 - a. Screening for *tobacco or nicotine use*; and
 - b. For those who *use tobacco or nicotine* products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
 - i. Four (4) *tobacco or nicotine* cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without *prior authorization*; and
 - ii. All Food and Drug Administration (FDA) approved *tobacco or nicotine* cessation medications (including both prescription and over-the-counter medications) for a 90-day *treatment* regimen when prescribed by a healthcare provider without *prior authorization*.
7. Colorectal Cancer Screening: Screening colonoscopy and sigmoidoscopy procedures, including related anesthesia services (for the purposes of colorectal cancer screening) will be covered under the preventive care services. Diagnostic endoscopic procedures (except screening colonoscopy and sigmoidoscopy), performed in an outpatient *facility* require the *copayment* or *coinsurance* applicable for outpatient *facility* services.

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

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

Notification

As required by section 2715(d)(4) of the Public Health Service Act, we will provide 60 days advance notice to *you* before any material modification will become effective, including any changes to preventive benefits covered under this *contract*. You may access *our* website or the Member Services Department at 1-855-650-3789 to get the answers to many of *your* frequently asked questions regarding preventive services. *Our* website has resources and features that make it easy to get quality care. *Our* website can be accessed at ambetter.homestatehealth.com.

You may also access the Federal Government's website at www.healthcare.gov/center/regulations/prevention.html to obtain current information.

If a service is considered diagnostic or routine chronic care, *your copayment, coinsurance and 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* and *coinsurance* charges. If *you* and/or *your* dependents receive any other *covered services* during a preventive care visit, *you* may be responsible to pay the applicable *copayment* and *coinsurance* for those services.

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 *health care professional* 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 the *member* chooses a non-network provider, that provider may request a *prior authorization*, but *approval* is not guaranteed.

Transplant Expense Benefits

Transplants are a covered benefit when a *member* is accepted as a transplant candidate and pre-authorized in accordance with this *policy*. Transplant services must be provided by an in-network Provider and *Facility*, and meet other medical criteria as set by medical management policy and the medical providers performing the transplant.

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 a *member* is an appropriate candidate for a *medically necessary* transplant, benefits will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting.
3. Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *member* to prepare for a later transplant, whether or not the transplant occurs.
4. The transplant itself, including the acquisition cost for the organ or bone marrow when authorized through the *Center of Excellence*).
5. Post-transplant follow-up.
6. Transportation for the *member*, any live donor, and the *immediate family* to accompany the *member* to and from the *facility* where the transplant will be performed.
7. Lodging for the *member*, any live donor and the *immediate family* accompanying the *member*

while the *member* is confined. 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.

Transplant Donor Expenses:

We will cover the medical expenses incurred by a live donor as if they were medical expenses of the *member* if:

1. They would otherwise be considered *covered service expenses* under the *contract*;
2. The *member* received an organ or bone marrow of the live donor; and
3. The transplant was a *medically necessary* transplant.

Ancillary "Center Of Excellence" Service Benefits:

A *member* may obtain services in connection with a *medically necessary* transplant from any *health care professional*. However, if a *medically necessary* transplant is performed in a *Center of Excellence*, *covered service expenses* for the *medically necessary* transplant will include the acquisition cost of the organ or bone marrow.

Non-Covered services and Exclusions:

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

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *medically necessary* transplant occurs.
2. For animal to human transplants.
3. To keep a donor alive for the transplant operation.
4. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
5. Related to transplants not included under this provision as a *medically necessary* transplant.

Food and Drug Administration (FDA) regulation, regardless of whether the trial is subject to FDA oversight. For a *medically necessary* transplant under study in an ongoing phase I or II clinical trial as set forth in the United States

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 *policy*. Such programs may include wellness programs, disease or *care management* programs, and other programs. 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.HomestateHealth.com or by contacting Customer Service by telephone at 855-650-3789 (TDD/TTY 711). The benefits are available as long as coverage remains active, unless changed by us as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All enrollees are eligible for program benefits upon obtaining coverage. The programs are optional, and the benefits are made available at no additional cost to the enrollees. The programs and

benefits available at any given time are made part of this *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 855-650-3789 (TDD/TTY 711).

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 *policy*. The benefits and services provided may include transportation to health services, assistance with childcare, access to healthy meals, and other relevant services based on need. The benefits are available as long as coverage remains active, unless changed by us.

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

Social determinants of health benefits and services may be offered to enrollees through the “My Health Pays” wellness program and through local health plan websites. Enrollees may receive notifications about available benefits and services through emails from local health plans and through the “My Health Pays” notification system. To inquire about these benefits and services or other benefits available, *you* may visit *our* website at Ambetter.HomestateHealth.com or by contacting Member Services at 855-650-3789 (TDD/TTY 711).

Urgent Care Service Benefits

Urgent care services include *medically necessary* services by in-network *health care professionals* and services provided at an *urgent care center* including *facility* costs and supplies. Care that is needed after a *primary care health care professional'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 facility*.

Members are encouraged to contact their *primary care health care professional* for an appointment before seeking care from another *health care professional*, but contracted *urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *primary care health care professional* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-855-650-3789 (TDD/TTY 711). The 24/7 Nurse Advice Line is available 24 hours a day, 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: For unanticipated or emergency health care services received in a network *facility* from a non-network provider, from the time you present an *emergency medical condition* until the time of discharge you will only be responsible for your standard cost-sharing amount. For services received in a non-network *facility*, you may be billed for the difference between the amount paid and the non-network provider's charge.

UTILIZATION REVIEW (AUTHORIZATION)

Prior Authorization Required

Some medical and *behavioral health covered services* require *prior authorization*. In general, *network providers* must obtain *prior authorization* from us prior to providing a *network eligible service* or supply to a *member*. However, there are some cases in which *you* must obtain the *prior authorization*. For example, if *you*:

1. Wish to receive a service or supply from a *non-network provider*; or
2. Are admitted into a *network facility* by a *non-network provider*; or
3. Are requesting a *non-covered service*

It is recommended that all services be provided by in-network *health care providers*. If *you* receive services from a *non-network health care provider*, or services that are not covered, and *you* do so without first obtaining *prior authorization*, *you* may be liable for all expenses.

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 must be obtained for the following services, except for Urgent Care or Emergency Services. This list is not exhaustive. To confirm if a specific service requires *Prior Authorization*, please contact Member Services.

- a. Non-Emergency Health Care Services provided by Non-Network Providers;
- b. Reconstructive procedures;
- c. Diagnostic Tests such as specialized labs, procedures and high technology imaging;
- d. Injectable drugs and medications;
- e. Inpatient Health Care Services;
- f. Specific surgical procedures;
- g. Nutritional supplements;
- h. Pain management services; and
- i. Transplant services.

Prior authorization requests (medical and *behavioral health*) can be submitted by *your* provider via telephone, eFax, or provider web portal. Although not required, submitting requests within the recommended timeframes below will allow for timely review of *prior authorization* requests:

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 healthcare except those *members* needing *home health care* after *hospital discharge*.

After *prior authorization* has been requested and all necessary information, including the results of any face-to-face clinical evaluation or second opinion that may be required has been submitted, *we* will notify *you* and *your* provider if the request has been approved as follows:

1. For immediate or urgent request situations, within sixty (60) minutes, when the lack of *treatment* may result in an *emergency* room visit or *emergency* admission.
2. For non-urgent pre-service requests regarding proposed admission, procedure or service within 36 hours, which shall include one business day of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination.
3. For post-service requests and *retrospective reviews*, *we* will make *our* determination within 30 calendar days of receipt of the request. *We* will notify *you* in writing of the determination within 10 days of making the determination.

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

How to Confirm Prior Authorization

To obtain *prior authorization* or to confirm that *your* 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

Network providers cannot bill *you* for services for which they fail to obtain *prior authorization* as required. In cases of emergency, benefits will not be reduced for failure to comply with *prior authorization* requirements. However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

Prior Authorization Does Not Guarantee Benefits

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

Payment for authorized services may be denied, and an authorization may be rescinded, if:

1. Such authorization is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition; or
2. The health benefit plan terminates before the health care services are provided; or
3. The covered person's coverage under the health benefit plan terminates before the health care services are provided.

If all terms and conditions of the *contract* are met and *we* authorize a proposed admission, *treatment*, or *covered service* expense by a *health care provider* based upon the complete and accurate submission of all necessary information relative to an eligible member, *we* shall not retroactively deny, revoke, or restrict this authorization within 45 business days if the *health care provider* renders the *covered service* expense in good faith and pursuant to the authorization.

Notice of Prior Authorization

If a *prior authorization* request is approved, the provider will be informed of the *approval* by telephone or electronically within 24 hours of making the decision. The *member* will be informed within two business days of the decision being made, and written or electronic confirmation of the telephone notification will be provided to the *member* and the provider within two business days of making the *adverse determination*.

A Notice of *prior authorization* includes:

1. The number of certified days of *hospital* confinement;
2. The medical *diagnosis*, and if applicable, the *surgical procedure* that was certified;
3. Instructions for a *health care professional* to request additional days of *hospital* confinement (if necessary); and
4. Instructions regarding questions about the *authorization* process.

Notice of Adverse Determination

If *treatment* is not medically appropriate and medically necessary, the provider will be informed of the *adverse determination* by telephone within twenty-four hours of making the *adverse determination*, and written or electronic confirmation of the telephone notification will be provided to the *member* and the provider within one business day of making the *adverse determination*.

The written notification of an *adverse determination* will include the principal reason or reasons for the determination, including the clinical rationale, and the instructions for initiating an *appeal* or reconsideration of the determination. We will provide the clinical rationale in writing for an *adverse determination*, including the clinical review criteria used to make that determination, to the *health care provider* and to any party who received notice of the *adverse determination*.

If a *member* decides to receive non-certified medical *treatment*, then no benefits are paid. The *member* may elect to file an *Appeal* with us. At all times, the final decision for actual medical *treatment* to be provided is the right and responsibility of the *member* and the *health care professional*.

Concurrent Review Determinations

For *concurrent review* determinations, a determination will be made within one business day of obtaining all necessary information. In the case of a determination to certify an extended stay or additional services, the *provider* rendering the service will be notified by telephone within one business day of making the *authorization*, and written or electronic confirmation of the telephone notification will be provided to the *member* and the *provider* within one business day after the telephone notification. The notification will include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

In the case of an *adverse determination*, the *provider* rendering the service will be notified by telephone within twenty-four hours of making the *authorization*, and written or electronic confirmation of the telephone notification will be provided to the *member* and the *provider* within one business day after the telephone notification. In any case, services will be continued without liability to the *member* until the *member* has been notified of a determination.

Concurrent Care Decisions

Reduction or termination of ongoing plan of *treatment*: If we have approved an ongoing plan or course of *treatment* that will continue over a period of time or a certain number of *treatments* and we notify you that we have decided to reduce or terminate the *treatment*, we will give you notice of that decision allowing sufficient time to *appeal* the determination and to receive a decision from us before any interruption of care occurs.

Request to extend ongoing *treatment*: If you have received *approval* for an ongoing *treatment* and wish to *extend the treatment* beyond what has already been approved, we will consider your *appeal* as a request for urgent care. If you request an extension of *treatment* at least 24 hours before the end of the *treatment* period, we must notify you soon as possible but no later than 24 hours after receipt of the claim.

An *appeal* of this decision is conducted according to the urgent care *appeals* procedures.

Concurrent urgent care and extension of *treatment*: Under the concurrent care provisions, any request that involves both urgent care and the extension of a course of *treatment* beyond the period of time or number of *treatments* previously approved by *us* must be decided as soon as possible, taking into account the medical urgencies, and notification must be provided to the *claimant* within 24 hours after receipt of the claim, provided the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of *treatments*.

Non-urgent request to extend course of *treatment* or number of *treatments*: If a request to extend a course of *treatment* beyond the period of time or number of *treatments* previously approved by *us* does not involve urgent care, the request may be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, e.g., as a *pre-service claim* or a post-service claim.

If the request is not made at least 24 hours prior to the expiration of the prescribed period of time or number of *treatments*, the request must be treated as a *Claim involving urgent care* and decided in accordance with the urgent care claim timeframes, e.g., as soon as possible, taking into account the medical emergencies, but not later than 72 hours after receipt.

Retrospective Review Determinations

For *retrospective review* determinations, a determination will be made within thirty business days of receiving all necessary information. A written notice of the determination will be provided to the *member* within ten business days of making the determination.

Reconsideration of Determination

In a case involving an initial determination or a *concurrent review* determination, the *provider* rendering the service may request on behalf of the *member* a reconsideration of an *adverse determination* by the reviewer making the *adverse determination*. The reconsideration will occur within one business day of the receipt of the request and will be conducted between the *provider* rendering the service and the reviewer who made the *adverse determination* or a clinical peer designated by the reviewer if the reviewer who made the *adverse determination* is not available within one business day. If the reconsideration process does not resolve the difference of opinion, the *adverse determination* may be appealed by the *member* or the *provider* on behalf of the *member*. Reconsideration is not a prerequisite to a standard *appeal* or an expedited *appeal* of an *adverse determination*.

Notification

It is *your* responsibility to notify *us* and arrange for the release of necessary medical information from *your health care professional* to the Utilization Review Organization. *You* may also arrange for the *hospital* or *your health care professional* to notify the Utilization Review Organization; however, if for any reason *your health care professional* or *hospital* fails to cooperate, the penalty applies as described in the "Failure to Obtain Prior Authorization" provision of this section.

Notification is required for all *hospital confinements, psychiatric care, outpatient surgeries, major diagnostic tests, home health care, extended care facility confinements, hospice services, rehabilitation facility confinements, skilled nursing facilities* and transplants. Notification **MUST** take place at least two weeks prior to the scheduled confinement, *treatment* or service.

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

*See page 68 for additional information regarding unanticipated or emergency healthcare services.

Although healthcare services may be or have been provided to you at a healthcare 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 health care professionals 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. Please see the “Eligible Service Expense” definition for more information.

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/surcharges imposed on the *member* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.
3. Any services performed by a *member* of a *member's immediate family*.
4. Any services not identified and included as *covered service expenses* under the *policy*. You will be fully responsible for payment for any services that are not *covered service expenses*.
5. Any services where other coverage is primary to Ambetter must be first paid by the primary payor prior to consideration for coverage under Ambetter.
6. Any non-medically necessary court ordered care for a medical/surgical or mental health/*substance use disorder diagnosis*, unless required by state law

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*.
2. For any portion of the charges that are in excess of the *eligible service expense*.
3. For weight modification, bariatric *surgery*, or for surgical *treatment* of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery* and weight loss programs, except as specifically covered in this *policy*.
4. For breast reduction or augmentation.
5. For the reversal of sterilization and the reversal of vasectomies. Reversal of non-elective sterilizations resulting from *illness* or *injury* is covered.
6. For abortion (unless *medically necessary* or the life of the mother would be endangered if the fetus were carried to term).
7. For artificial insemination (AI), assisted reproductive technology (ART) procedures or the diagnostic tests and drugs to support AI or ART procedures.
8. For expenses for television, telephone, or expenses for other persons.
9. For marriage, family, or child counseling for the *treatment* of premarital, marriage, family, or child relationship dysfunctions.
10. For telephone consultations, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
11. For stand-by availability of a *medical practitioner* when no *treatment* is rendered.
12. 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 Benefits.
13. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect.
14. For cosmetic breast reduction or augmentation, except for the *medically necessary treatment* of Gender Dysphoria.
15. For *diagnosis* or *treatment* of nicotine addiction, except as otherwise covered under the Preventive Care Expense Benefits provision of this *policy*.

16. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Expense Benefits.
17. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
18. While confined primarily to receive *rehabilitation, custodial care*, educational care, or nursing services (unless expressly provided for in this *contract*).
19. For vocational or recreational therapy, vocational *rehabilitation, outpatient* speech therapy, or occupational therapy, except as expressly provided for in this *policy*.
20. 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.
21. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this
22. For the *treatment* of infertility except as expressly provided in this *policy*.
23. 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.
24. For *treatment* received outside the United States, except for a medical *emergency* while traveling for up to a maximum of 180 consecutive days. If travel extends beyond 180 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 180 days.
25. 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.
26. For fetal reduction *surgery*.
27. 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.
28. As a result of any *injury* sustained while at a *residential treatment facility*.
29. 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.
30. For the following miscellaneous items: artificial insemination (except where required by federal or state law); blood and blood products; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *rehabilitation* services for the enhancement of job, athletic or recreational performance; routine or elective care outside the *service area*; *treatment* of spider veins; transportation expenses, unless specifically described in this *policy*.
31. For court ordered testing or care unless *medically necessary*.
32. Domiciliary care provided in a residential institution, *treatment* center, halfway house, or school

- because a *member's* own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
33. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
 34. Services or supplies eligible for payment under either federal or state programs (except Medicaid). This exclusion applies whether or not *you* assert *your* rights to obtain this coverage or payment of these services.
 35. Biofeedback.
 36. Mental Health Services are excluded:
 - a. Evaluation for the purpose of maintaining employment. Benefits will be allowed for services that are medically necessary and would otherwise be covered under this *policy*.
 37. *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.
 38. For any medicinal and recreational use of cannabis or marijuana.
 39. Vehicle installations (modifications) which may include but are not limited to: adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.
 40. For all health care services obtained at an Urgent Care *Facility* that is a Non-network Provider.
 41. Immunizations that are not medically necessary or medically indicated. This includes those used for travel and occupational.
 42. For expenses, services, and *treatments* from a massage therapist to touch and manipulate the muscles and other soft tissues of the body.
 43. 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.
 44. For expenses, services, and *treatments* from a Naturopathic specialists for *treatment* of prevention, self-healing and use of natural therapies.

TERMINATION

Termination of Contract

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *policy*.
2. The date *we* receive a request from *you* to terminate this *contract*, or any later date stated in *your* request, or if *you* are enrolled through the Health Insurance Marketplace, the date of termination that the Health Insurance Marketplace provides us upon *your* request of cancellation to the Health Insurance Marketplace.
3. 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 *you* are the only *member* on this *policy*.
6. The date *your* eligibility for insurance under this *policy* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *policy*.
7. The date *your* eligibility for coverage under this *policy* ceases as determined by the Health Insurance Marketplace.

If this *policy* is other than an individual coverage only plan (i.e. includes family coverage), it may be continued after *your* death:

1. By *your spouse*, if a *member*; otherwise,
2. By the youngest child who is a *member*.

This *policy* will be changed to a plan appropriate, as determined by *us*, to the *member(s)* that continue to be covered under it. *Your spouse* or youngest child will replace *you* as the primary *member*. A proper adjustment will be made in the premium required for this *policy* to be continued. *We* will also refund any premium paid and not earned due to *your* death. The refund will be based on the number of full months that remain to the next premium due date.

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-Marketplace *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 *policy*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180-Day Notice: If *we* discontinue offering and refuse to renew all individual *contracts* in the individual market in the state where *you* reside, *we* will provide a written notice to *you* and the Director of the Missouri Department of Commerce and 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.

Portability of Coverage

If a person ceases to be a *member* due to the fact that the person no longer meets the definition of *dependent member* under the *contract*, the person will be eligible for continuation of coverage. If elected, we will continue the person's coverage under the *policy* by issuing an individual *policy*. The premium rate applicable to the new *policy* will be determined based on the *residence* of the person continuing coverage. All other terms and conditions of the new *policy*, as applicable to that person, will be the same as this *contract*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new *policy* to the extent satisfied under this *policy* at the time that the continuation of coverage is issued. (If the original coverage contains a family *deductible* which must be met by all *members* combined, only those expenses incurred by the *member* continuing coverage under the new *policy* will be applied toward the satisfaction of the *deductible amount* under the new *policy*.)

Reinstatement

If any premium is not paid by the end of the grace period *your* coverage will terminate. Later acceptance of premium by *us*, within *four* calendar days of the end of the grace period, will reinstate *your policy* with no break in *your* coverage. *We* will refund any premium that *we* receive after this four-day period. Reinstatement shall not change any provisions of the *policy*.

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.

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. Notice given by or on behalf of *you* at 11720 Borman Drive, St. Louis, MO 63146, or to any authorized agent of *ours*, with information sufficient to identify *you*, will be deemed notice to *us*.

Claim Forms

Upon receipt of a notice of claim, *we* will furnish to *you* or *your dependent* such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice *you* or *your dependent* will be deemed to have complied with the requirements of this *policy* as to *proof of loss* upon submitting, within the time fixed in the *policy* for filing proofs of loss, written proof covering the occurrence, the character and the extent of the *loss* for which claim is made.

Proof of Loss

Written *proof of loss* must be furnished to *us* in case of claim for *loss* for which this *policy* provides any periodic payment contingent upon continuing *loss* within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other *loss* within ninety days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. Subject to due written proof of loss, all accrued indemnities for *loss* for which this *policy* provides periodic payment will be paid monthly.

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*, or
- *You* have an out-of-area emergency.

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

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

Ambetter from Home State Health Plan
Attn: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

Cooperation Provision

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

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

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

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

Time for Payment of Claims

Benefits will be paid immediately upon receipt of *proof of loss*. Should *we* determine that additional supporting documentation is required to establish responsibility of payment, *we* shall pay benefits upon receipt of such additional supporting documentation.

Payment of Claims

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

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

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

If a proper claim is submitted by a public *hospital* or clinic, benefits payable will be paid to such *hospital* or clinic with or without an assignment from *you* or *your dependent*. Payment of benefits to the public *hospital* or clinic pursuant to this paragraph shall discharge *us* from all liability to *you* or *your dependent* to the extent of benefits paid.

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.homestatehealth.com.

The amount of reimbursement will be based on the following:

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

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

Assignment

We will reimburse a *hospital* or *health care provider* if:

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

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

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 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. *We*, at *our* own expense, have the right and opportunity to make an autopsy of *member* in case of death where it is not forbidden by law.

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 Third Party Beneficiaries

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

COMPLAINT AND APPEAL PROCESS

The following processes are available to address *your* problems and concerns. In addition, communicating a *complaint* or *appeal* will not affect *your* healthcare benefits or services and *we* will not treat *you* differently.

Call Member Services

We want to know *your* concerns so *we* can improve *our* services. Please contact *our* Member Services team at 1-855-650-3789 (TDD/TYY) 711 if *you* have questions or concerns. *We* will attempt to resolve *your* concern on *your* initial contact.

Complaint Process

You or *your* authorized representative may file a *complaint* by calling *our* Member Services Team at 1-855-650-3789 (TTY/TDD 711) or in writing by mailing or faxing *your* grievance to:

Ambetter from Home State Health
Attn: Grievance Department
11720 Borman Drive
St. Louis, MO 63146
Fax: 1-855-805-9812

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

Resolution Timeframe

Complaints will be promptly investigated. *We* will acknowledge *your* *complaint* by sending *you* a letter within ten (10) business days of receipt of *your* *complaint*.

We will investigate *your* *complaint* within twenty (20) business days after receipt of the *complaint*, unless the investigation cannot be completed within this time. If the investigation cannot be completed within twenty (20) business days after receipt of the *complaint*, the enrollee shall be notified in writing on or before the twentieth (20th) business day and the investigation shall be completed within thirty (30) business days thereafter. The notice shall set forth with specificity the reasons for which additional time is needed for the investigation.

Urgent *complaints* are resolved as expeditiously as possible, no later than seventy-two (72) hours after Home State Health receives the *complaint*.

Within five (5) business days after the investigation is completed, someone not involved in the circumstances giving rise to the *complaint* or its investigation will decide upon the appropriate resolution of the *complaint* and notify *you* in writing of the health carrier's decision regarding the *complaint* and of the right to file an *appeal*. Within fifteen (15) business days after the investigation is completed, *we* will notify the person who submitted the *complaint* of the resolution of said *complaint*.

If *you* are not satisfied with *our* response or decision, *you* may file an *appeal*. For *adverse determinations*, *your* provider also has the opportunity to request a review with the Ambetter clinician who made the decision or

a clinical peer.

Appeal Process

You have up to 180 calendar days to file an *Appeal* from the date you receive the decision that you are requesting be overturned. You or your Authorized Representative may file an *appeal* in writing by mail or by fax at 1-855-805-9812. Please send your written *Appeal* to:

Ambetter from Home State Health
Attn: Appeals Department
11720 Borman Drive
St. Louis, MO 63146

When filing your *Appeal*, we ask that you provide a reason along with any information to support why your *Appeal* should be approved. If you would like to file your *Appeal* by telephone, you may call Member Services at 1-855-650-3789 (TDD/TTY 711). However, your verbal *appeal* must be followed up with a written *appeal* request.

Please include in your written *appeal* or be prepared to tell us the following:

1. Name, address and telephone number of the *member*;
2. The *member's* health plan identification number;
3. Name of *health care provider*, address and telephone number;
4. Date the health care benefit was provided (if a post-claim denial *appeal*)
5. Name, address and telephone number of an *authorized representative* (if *appeal* is filed by a person other than the *member*); and
6. A copy of the notice of *adverse benefit determination*, if applicable

Who Can File an Appeal

You have the right to have someone else help you with filing an *appeal*. This can be a relative, friend, lawyer, your doctor or *health care provider*, or other person. To have someone else file an *appeal* for you, we must have your written permission for that person to file an *appeal* on your behalf. You will need to obtain and fill out an Authorized Representative Form and return it to us so we will know who you have granted permission to represent you. The Authorized Representative Form can be obtained by calling Member Services at 1-855-650-3789 (TDD/TTY 711) or by visiting our website at ambetter.homestatehealth.com.

Rescission of coverage

If we rescind (withdraw) your coverage, you may file an *appeal* according to the following procedures. We cannot terminate your benefits until all of the *appeals* have been exhausted. Since a *rescission* means that no coverage ever existed, if our decision to rescind is upheld, you will be responsible for payment of all claims for your health care services.

Resolution Timeframe

If you file an *Appeal*, an acknowledgement letter will be sent within ten (10) business days from when the *Appeal* was received by Ambetter.

The *appeal* investigation will be completed and response provided within twenty (20) business days after receipt of your *appeal* or within thirty (30) calendar days, whichever is less. If additional time is needed and agreed upon by you, you will be notified in writing before the twentieth (20th) business day with specific reasons why the additional time is needed and the additional time will be no greater than fourteen (14) calendar days. Within five (5) business days after the investigation resolution someone not involved in the circumstances giving rise to the *appeal* or its investigation will decide upon the appropriate resolution of the *appeal* and notify the you in writing of our decision regarding the *appeal*.

Expedited Review

You or your representative or provider acting on your behalf may request an expedited review when a non-expedited review would reasonably appear to seriously jeopardize the life or health of the member or jeopardize the member's ability to regain maximum function. A request for an expedited review may be submitted orally or in writing.

Upon receipt of request for an expedited review of a determination, *we* will notify *you* within 72 hours and written confirmation provided within 3 business days of the determination notice.

Access to Documents Relevant to the Appeal

You are entitled to receive, upon request and at no additional cost, reasonable access to and copies of all documents relevant to the appeal including any new or additional evidence. Relevant documents include documents and records relied upon in making the appeal decision and documents and records submitted in the course of making the appeal decision.

Filing a Complaint or Grievance with the Missouri Department of Commerce and Insurance,

You have the right to file a complaint or grievance with the Missouri Department of Commerce and Insurance (DCI) at any time. The Missouri Department of Commerce and Insurance may be contacted at the following address and telephone number:

**Missouri Department of Commerce and Insurance
Attn: Division of Consumer Affairs
P.O. Box 690
Jefferson City, MO 65102
Phone: 1-800-726-7390**

Request for External Review by an Independent Review Organization

If the Missouri Department of Commerce and Insurance is unable to resolve your appeal regarding the medical necessity, appropriateness, health care setting, level of care, or effectiveness of healthcare service, the Missouri Department of Commerce and Insurance may select an Independent Review Organization (IRO) to review your appeal.

For the purposes of the *appeals* process, an *Independent Review Organization (IRO)* means an entity that is accredited by a nationally recognized private accrediting organization to conduct independent external reviews of adverse benefit determinations and by the Missouri Department of Commerce and Insurance in accordance with Missouri law. The IRO is composed of persons who are not employed by Ambetter or any of its affiliates.

If the director of the DCI determines an *appeal* is unresolved after completion of DCI's consumer *complaint* process, DCI shall refer the unresolved *appeal* to an IRO. An unresolved *appeal* shall include a difference of opinion between a treating *health care professional* and the health carrier concerning the medical necessity, appropriateness, health care setting, level of care or effectiveness of a health care service.

The DCI will provide the IRO and upon request the member, *member's* representative or health carrier copies of all medical records and any other relevant documents which the DCI has received from any party. The member, *member's* representative and health carrier may review all the information submitted to the IRO for consideration.

The member, *member's* representative or health carrier may also submit additional information to the DCI which the DCI shall forward to the IRO. All additional information must be received by the DCI. If a member, *member's* representative or health carrier has information which contradicts information already provided the IRO, they should provide it as additional information. All additional information should be received by the DCI within fifteen

(15) business days from the date the DCI mailed that party copies of the information provided to the IRO. An envelope's postmark shall determine the date of mailing. Information may be submitted to the DCI by means other than mail if it is in writing, typeset or easily transferred into typeset by the DCI's technology and a date of transmission is easily determined by the DCI. At the DCI's discretion, additional information which is received past the fifteen (15) working-day deadline may be submitted to the IRO.

The IRO shall request from the DCI any additional information it wants. The DCI shall gather the requested information from a *member*, *member's* representative or health carrier or other appropriate entity and provide it to the IRO. If the DCI is unable to obtain the requested information, the IRO shall base its opinion on the information already provided.

Within twenty (20) calendar days of receiving all material, the IRO shall submit to the DCI its opinion of the issues reviewed. Under exceptional circumstances, if the IRO requires additional time to complete its review, it should request in writing from the director an extension in the time to process the review, not to exceed five (5) calendar days. Such a request should include the reasons for the request and a specific time at which the review is expected to be complete.

After the director receives the IRO's opinion, the director shall issue a decision which shall be binding upon the enrollee and the health carrier. The director's decision shall be in writing and must be provided to the enrollee and health carrier within twenty five (25) calendar days of receiving the IRO's opinion. In no event shall the time between the date the IRO receives the request for external review and the date the enrollee and the health carrier are notified of the director's decision be longer than forty-five (45) days.

An enrollee or enrollee's representative or health carrier may request an expedited external review if the *adverse determination*:

(A) Concerns an admission, availability of care, continued stay, or health care service for which the enrollee received emergency services, but has not been discharged from a *facility*; or

(B) Involves a medical condition for which the delay occasioned by the standard external review time frame would jeopardize the life or health of the enrollee or jeopardize the enrollee's prognosis or ability to regain maximum function.

As expeditiously as possible after receipt of the request for expedited external review by the IRO, the IRO must issue its opinion as to whether the *adverse determination* should be upheld or reversed and submit its opinion to the director. As expeditiously as possible, but within no more than seventy-two (72) hours after the receipt of the request for expedited external review by the IRO, the director shall issue notice to the enrollee and the health carrier of the director's determination and may issue a decision to uphold or reverse the *adverse determination*. If the notice is not in writing, the director must provide the written decision within forty-eight (48) hours after the date of the notice of the determination.

If a request for external review of an *adverse determination* involves a denial of coverage based on a determination that the health care service or *treatment* recommended or requested is experimental or investigational, the following additional requirements must be met:

(A) The IRO shall make a preliminary determination as to whether the recommended or requested health care service or *treatment* that is the subject of the *adverse determination* is a covered benefit under the person's health benefit plan except for the health carrier's determination that the service or *treatment* is experimental or investigational for a particular medical condition; and is not explicitly listed as an excluded benefit under the enrollee's health benefit plan with the health carrier;

(B) The request for external review of an *adverse determination* involving a denial of coverage based on a health carrier's determination that the health care service or *treatment* recommended or requested is experimental or investigational must include a certification from the enrollee's *physician* that:

1. Standard health care services or *treatments* have not been effective in improving the condition of the enrollee; or
2. Standard health care services or *treatments* are not medically appropriate for the enrollee; or
3. There is no available standard health care service or *treatment* covered by the health carrier that is more beneficial than the recommended or requested health care service or *treatment*; and
4. The request for external review of an *adverse determination* involving the denial of coverage based on a determination that the requested *treatment* is experimental or investigational shall also include documentation
 - a) that the enrollee's treating *physician* has recommended a health care service or *treatment* that the *physician* certifies, in writing, is likely to be more beneficial to the enrollee, in the physician's opinion, than any available standard health care services or *treatments*; or
 - b) that the enrollee's treating physician, who is a licensed, board-certified, or board-eligible *physician* qualified to practice in the area of medicine appropriate to treat the enrollee's condition, has certified in writing that scientifically-valid studies using accepted protocols demonstrate that the health care service or *treatment* requested by the enrollee that is the subject of the *adverse determination* is likely to be more beneficial to the enrollee than any available standard health care services or *treatments*;

(C) When conducting such an external review, the IRO must select one or more clinical peers, who must be physicians or other *health care professionals* who meet minimum qualifications and through clinical experience in the past three (3) years are experts in the *treatment* of the enrollee's condition and knowledgeable about the recommended or requested health care service or *treatment*. Each clinical peer shall provide a written opinion to the assigned IRO on whether the recommended or requested health care service or *treatment* should be covered; and

(D) Each such clinical peer's opinion submitted to the IRO shall include the following information:

1. A description of the enrollee's medical condition;
2. A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or *treatment* is more likely than not to be beneficial to the enrollee than any available standard health care services or *treatments* and the adverse risks of the recommended or requested health care service or *treatment* would not be substantially increased over those of available standard health care services or *treatments*;
3. A description and analysis of any medical or scientific evidence considered in reaching the opinion;

4. Information on whether the reviewer's rationale for the opinion is based upon whether the recommended or requested health care service or *treatment* has been approved by the federal Food and Drug Administration for the condition, or whether medical or scientific evidence or evidence based standards demonstrate that the expected benefits of the recommended or requested health care service or *treatment* is more likely than not to be beneficial to the covered person than any available standard health care service or *treatment* and the adverse risks of the recommended or requested health care service or *treatment* would not substantially be increased over those of available standard health care services or *treatments*; and
5. A description and analysis of any evidence-based standard.

If we decide to reverse *our adverse determination* before or during the external review, we will notify *you* and the Missouri Department of Commerce and Insurance, within one business day of the decision.

If the IRO reverses *our* decision, we will immediately provide coverage for the health care service or services in question.

If the IRO and Missouri Department of Commerce and Insurance upholds *our* decision, *you* may have a right to file a lawsuit in any court having jurisdiction.

GENERAL PROVISIONS

Entire Contract

This *contract*, with the application, *schedule of benefits* and any rider-amendments is the entire *policy* between *you* and *us*. No change in this *policy* will be valid unless it is approved by one of *our* officers and noted on or attached to this *policy*. No agent may:

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

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.homestatehealth.com/privacy-practices.html> or call Member Services at 855-650-3789 (TDD/TTY 711).

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

Language

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

Non-Waiver

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

Rescissions

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

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

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 *policy* or in filing a claim for *policy* benefits, *we* have the right to demand that *member* pay back to *us* all benefits that *we* provided or paid during the time the *member* was covered under the *policy*.

Time Limit on Certain Defenses

After two years from the date of issue of this *policy* no misstatements, except fraudulent misstatements, made by *you* in the application for *your policy* may be used to void *your policy* or to deny a claim for *loss* incurred commencing after the expiration of such two-year period. In accordance with the foregoing, *we* have the right to terminate this *policy* if *you* commit fraud or make a material misrepresentation during the application process, or *we* determined it appropriate to comply with law.

No claim for *loss* incurred commencing after two years from the date of issue of this *policy* will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of *loss* had existed prior to the *effective date* of coverage of this *policy*.

Conformity with State Laws

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

Statement of Non-Discrimination

Ambetter from Home State Health 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 Home State Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Home State Health:

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

If *you* need these services, contact Ambetter from Home State Health at 1-855-650-3789 (TTY/TDD 711).

If *you* believe that Ambetter from Home State Health 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: Grievance/Appeals Home State Health, 11720 Borman Drive, St. Louis, MO 63146, 1-855-650-3789 (TTY/TDD 711), Fax 1-855-805-9812. *You* can file a *grievance* by mail, fax, or email. If *you* need help filing a *grievance*, Ambetter from Home State Health is available to help you. *You* can also file a civil rights *complaint* with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

Declaración de no discriminación

Ambetter de Home State Health 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 Home State Health no excluye personas o las trata de manera diferente debido a su raza, color, origen nacional, edad, discapacidad, o sexo.

Ambetter de Home State Health:

- 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 Home State Health a 1-855-650-3789 (TTY/TDD 711).

Si considera que Ambetter de Home State Health 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: Grievance/Appeals Home State Health, 11720 Borman Drive, St. Louis, MO 63146, 1-855-650-3789 (TTY/TDD 711), Fax 1-855-805-9812. Usted puede presentar una queja por correo, fax, o correo electrónico. Si necesita ayuda para presentar una queja, Ambetter de Home State Health 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>.



FROM



Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Home State Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Home State Health 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 1-855-650-3789 (TTY/TDD 1-877-250-6113)。
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Home State Health, 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 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Serbo-Croatian:	Ako Vi, ili neko kome pomažete, imate pitanja u vezi Ambetter from Home State Health, imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-855-650-3789 (TTY/TDD 1-877-250-6113).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Home State Health 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 1-855-650-3789 (TTY/TDD 1-877-250-6113) an.
Arabic:	إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from Home State Health، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Home State Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-855-650-3789 (TTY/TDD 1-877-250-6113)로 전화하십시오.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Home State Health вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-855-650-3789 (TTY/TDD 1-877-250-6113).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Home State Health, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Tagalog:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from Home State Health 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 1-855-650-3789 (TTY/TDD 1-877-250-6113) पर कॉल करें।
Pennsylvania Dutch:	Vann du, adda ebbah's du am helfa bisht, ennichi questions hott veyyich Ambetter from Home State Health, dann hosht du's recht fa hilf greeya adda may aus finna diveyya in dei shprohch un's kosht nix. Fa shvetza mitt ebbah diveyya, kawl 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Persian:	اگر شما، یا کسی که به او کمک می کنید سؤالی در مورد Ambetter from Home State Health دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. برای صحبت کردن با مترجم با شماره 1-855-650-3789 (TTY/TDD 1-877-250-6113) تماس بگیرید.
Cushite:	Yoo sii ykn namaa gargaaraa jirtuu wa'ee Ambetter from Home State Health irra gaaffi qabaatan ta'ee gargaarsaa fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana wajiin dubadhuu, 1-855-650-3789 irra bilbilli (TTY/TDD 1-877-250-6113).
Portuguese:	Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from Home State Health, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Amharic:	እርስዎ ወይም እርስዎ የሚርዱት ሰው ስለ Ambetter from Home State Health ጥያቄ ካለዎት ያለምንም ወጪ በቋንቋዎ ድጋፍ እንዲሁም መረጃ የማግኘት መብት አለዎት፤ እስተርጓሚ ለማነጋገር በ 1-855-650-3789 (TTY/TDD 1-877-250-6113) ይደውሉ፤

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Member Services Department: 1-855-650-3789

TDD/TTY 711

Log on to: Ambetter.homestatehealth.com

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