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Insured by Celtic Insurance Company

2023 Evidence of Coverage
Ambetter + Adult Vision + Adult Dental

Ambetter.SunshineHealth.com

21663FL018-2023

Celtic Insurance Company
Ambetter from Sunshine Health
Ambetter + Adult Vision + Adult Dental
Home Office: 200 East Randolph, Chicago, IL 60601
Individual *Member* Contract

In this *contract,* the terms "you," "your" or "yours" will refer to the *member* or any dependents enrolled in this *contract***.** The terms "we," "our," or "us" will refer to Celtic Insurance Company or Ambetter from Sunshine Health.

AGREEMENT AND CONSIDERATION

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

Please read the copy of the application attached to this *contract*. Carefully check the application and write to the company at the address listed at the top of this page within 10 days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. This application is a part of the *contract* and the *contract* was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

GUARANTEED RENEWABLE

Annually, we must file this product, the cost share and the rates associated with it for approval. Guaranteed renewable means that your plan will be renewed into the subsequent year's approved product on the anniversary date unless terminated earlier in accordance with *contract* terms. You may keep this *contract* (or the new *contract* you are mapped to for the following year) in force by timely payment of the required premiums. In most cases you will be moved to a new *contract* each year, however, we may decide not to renew the *contract* as of the renewal date if: (1) we decide not to renew all *contracts* issued on this form, with a new *contract* at the same metal level with a similar type and level of benefits, to residents of the state where you then live; (2) we withdraw from the service area, 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 *contract* in the following events: (1) non-payment of premium; (2) a *member* fails to pay any *deductible* or *copayment amount* in excess of $300 owed to us and not the provider of services within 90 days after the date of the procedure; (3) a *member* is found to be in material breach of this *contract;* or (4) a change in federal or state law, no longer permits the continued offering of such coverage, such as CMS guidance related to individuals who are Medicare eligible. Rate changes are effective on a *member's* annual renewal date and will be based on each *member's* attained age, family structure, geographic region, *tobacco* usage and benefit plan at the time of renewal. We have the right to change premiums. We will notify the *member* in writing at least 45 days prior to the renewal date of any change in premium rates. If we discontinue offering and decide not to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 180 days prior to the date that we discontinue coverage.

At least 45 days advanced written notice of any plan to take an action or make a change permitted by this clause will be delivered to you at your last address as shown in our records. We will make no change in

your premium solely because of claims made under this *contract* or a change in a *member's* health. While this *contract* is in force, we will not restrict coverage already in force.

Annually, 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 calendar year.

TEN DAY RIGHT TO RETURN CONTRACT

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

This *contract* contains a *Deductible* provision.

This *contract* contains *prior authorization* requirements. You **may be required to obtain a referral from a primary care physician (*PCP)* in order to receive care from a *specialist provider*. Benefits may be reduced or not covered if the requirements are not met. Please refer to your schedule of benefits and the *Prior Authorization* Section.**

Celtic Insurance Company

Kevin J. Counihan, President

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INTRODUCTION

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

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

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

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

Throughout this *contract* you will see references to Celtic Insurance Company and Ambetter from Sunshine Health. Ambetter from Sunshine Health operates under its legal entity, Celtic Insurance Company, and both may be referred to as the "plan."

How to Contact Us
Ambetter from Sunshine Health
P.O. Box 459089
Fort Lauderdale, FL 33345-9089

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

Member Services	1-877-687-1169
Relay FL	1-800-955-8770
Fax	1-866-796-0523
Emergency	**911**
24/7 Nurse Advice Line	1-855-604-1303

Interpreter Services
Ambetter from Sunshine Health has a free service to help our *members* who speak languages other than English. These services ensure that you and your *provider* can talk about your medical or *behavioral health* concerns in a way that is most comfortable for you. Our interpreter services are provided at no cost to you. We have representatives that speak Spanish and medical interpreters to assist with other languages. *Members* who are blind or visually impaired and need help with interpretation can call *Member* Services for an oral interpretation.

To arrange for interpretation services, please call *Member* Services at 1-877-687-1169 or for the hard of hearing Relay FL 1-800-955-8770.

MEMBER RIGHTS AND RESPONSIBILITES

We are committed to:

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

If you have difficulty locating a *PCP*, *specialist physician, hospital* or other *network provider* please contact us so we can assist you with accessing or in locating a *network provider*. *Physicians* within out *network* may be affiliated with different *hospitals.* Our online directory can provide you with information for the *network hospitals*. The online directory also lists affiliations that your *provider* may have with *non-network hospitals*. Your Ambetter coverage requires you to use *network providers* with limited exceptions.

You have the right to:

1. Participate with your *provider* and *medical practitioners* in decisions about your health care. This includes working on any treatment plans and making care decisions. You should know any possible risks, problems related to recovery, and the likelihood of success. You shall not have any treatment without consent freely given by you or your legally *authorized representative.* You will be informed of your care options.
2. Know who is approving and performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which you have coverage.
4. Be treated with respect and dignity.
5. Privacy of your personal health information, consistent with state and federal laws, and our policies.
6. Receive information or make recommendations, including changes, about our organization and services, our *network* of *physicians, medical practitioners*, *hospitals*, other facilities, and your rights and responsibilities.
7. Make recommendations regarding our *member* rights and responsibilities policy.
8. Candidly discuss with your *provider* and *medical practitioners* appropriate and *medically necessary* care for your condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *PCP* about what might be wrong (to the level known), treatment and any known likely results. Your *PCP* 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 representative*. Your *provider* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
9. Voice *complaints* or *grievances* about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided. Refer to *Complaints* and *Grievances* section of this *contract* for more information.
10. See your medical records.
11. Be kept informed of *covered* and non-*covered services*, program changes, how to access services, *PCP* assignment, providers, advance directive information, referrals and *authorizations*, benefit denials, *member* rights and responsibilities, and our other rules and guidelines. We will notify you at least 60 days before the *effective date* of the modifications. Such notices shall include:

    a. Any changes in clinical review criteria; or
    b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
12. A current list of *network providers*. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
13. Adequate access to qualified medical practitioners and treatment or services regardless of age, ethnicity, race, religion, gender, sexual orientation, national origin, physical or mental disability, or expected health or genetic status. Access *medically necessary* urgent and *emergency services* 24 hours a day, seven days a week.
14. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.
15. Refuse treatment to the extent the law allows. You are responsible for your actions if treatment is refused or if the physician's instructions are not followed. You should discuss all concerns about treatment with your physician. Your physician can discuss different treatment plans with you, if there is more than one option that may help you. You will make the final decision.
16. Select your *PCP* within the *network*. You also have the right to change your *PCP* or request information on *network providers* close to your home or work.
17. Know the name and job title of people giving you care. You also have the right to know which *provider* is your *PCP*.
18. An interpreter when you do not speak or understand the language of the area.
19. A second opinion by a network provider, if you want more information about your treatment or would like to explore additional treatment options.
20. Make advance directives for healthcare decisions. This includes planning treatment before you need it.
21. Determine what actions should be taken regarding your health if you are no longer able to make decisions for yourself because of *illness* or because you are incapacited. You have the right to have your wishes known by completing Advance directives forms. Advance directives forms are forms you can complete to protect your rights for medical care. It can help your *PCP* 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; and
    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.
22. A second opinion by a *network* physician, if you want more information about your treatment or would like to explore additional treatment options.

You have the responsibility to:

1. Read this entire *contract*.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about your health that we or your medical practitioners need in order to provide care.
4. You should make it known whether you clearly understand your care and what is expected of you.
5. You need to ask questions of your *provider* until you understand the care you are receiving.
6. Review and understand the information you receive about your *Ambetter plan*. You need to know the proper use of *covered services*.
7. Show your *member* identification card and keep scheduled appointments with your *provider*, and call the *provider*'s office during office hours whenever possible if you have a delay or cancellation.

8. Know the name of your assigned *PCP*. You should establish a relationship with your *provider*.
9. You may change your *PCP* verbally or in writing by contacting our *Member* Services Department.
10. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
11. Follow the treatment plans and instructions for care that you have agreed on with your health care professionals and *provider*.
12. Tell your health care professional and *provider* if you do not understand your treatment plan or what is expected of you. You should work with your *PCP* 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.
13. Follow all health benefit plan guidelines, provisions, policies, and procedures.
14. Use any *emergency* room only when you think you have a medical *emergency*. For all other care, you should call your *PCP*.
15. When you enroll in this coverage, give all information about any other medical coverage you have. If, at any time, you get other medical coverage besides this coverage, you must tell us.
16. Pay your monthly premiums on time and pay all *deductible amounts, copayment amounts*, or *coinsurance amount* at the time of service.
17. Inform the entity through which you enrolled for this *contract* if you have any changes in your name, address, or family *members* covered under this *contract* within 60 days from the date of the event. These changes can also be done by logging into your consumer dashboard on member.ambetterhealth.com
18. Notify us or the entity you enrolled with of any enrollment related changes that would affect your *contract*, such as: birth of a child, or adoption, marriage, divorce, adding/removing a dependent, *spouse*/domestic partner be-comes eligible under a different insurer, enrollment changes, address change, or incarceration where *member* cost share would need to transfer from one *contract* to another *contract*.

IMPORTANT INFORMATION

Provider Directory

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

At any time, you can request a copy of the provider directory at no charge by calling *Member* Services at 1-877-687-1169 (Relay FL 1-800-955-8770). In order to obtain benefits, you may be required to designate a *PCP* for each *member.* We can help you choose a *PCP*. We can make your choice of *PCP* effective on the next business day.

Call the *PCP*'s office if you want to make an appointment. If you need help, call *Member* Services at 1-877-687-1169 (Relay FL 1-800-955-8770). We will help you make the appointment.

***Member* identification Card**

We will mail you a *Member* identification card after we receive your completed enrollment materials and you have paid your initial binder payment. This card is proof that you are enrolled in the Ambetter by Sunshine Health plan. You need to keep this card with you at all times. Please show this card every time you go for any service under the *contract*. The *Member* identification card will show your name, *member* identification number and *copayment amounts* required at the time of service. If you do not get your *Member* identification card within a few weeks after you enroll, please call *Member* Services at 1-877-687-1169 (Relay FL 1-800-955-8770). 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.SunshineHealth.com. It also gives you information on your benefits and services such as:

1. Finding a *network provider*, including *hospitals*, and pharmacies
2. Our programs and services, including programs to help you get and stay healthy.
3. A secure portal for you to check the status of your claims, make payments and obtain a copy of your *Member* identification card.
4. *Member* Rights and Responsibilities.
5. Notice of Privacy.
6. Current events and news.
7. Our Formulary or Preferred Drug List
8. *Deductible* and *copayment amount* accumulators.
9. Selecting a *PCP*.
10. Health Risk Assessment form, "Welcome Survey."

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

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

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

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

Protection from Balance Billing
Under Federal law, effective January 1, 2022, n*on-network providers* or facilities are prohibited from *Balance Billing* health plan *Members* for:

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

Please review the Access to Care and *Covered Services* sections of this *Contract* for detailed information.

DEFINITIONS

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

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

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

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

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

Allowed amount (also see *Eligible 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 amount*) per the *Member's* benefits. This amount excludes any payments made to the *Provider* by us as a result of Federal or State Arbitration.

Please note, if you receive services from a *non-network provider*, you may be responsible for the difference between the amount the *Provider* charges for the service (*Billed Amount*) and the *Allowed Amount* that we pay. However, you will not be responsible for *balance billing* for unanticipated out-of-*network* care that is otherwise covered under your plan and that is provided by a *non-network provider* at a *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 *member* identification 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.sunshinehealth.com/health-plans/our-benefits/ambetter-telehealth.html.

Appeal means a *grievance* that is related to a denial of services or a claim in whole or part, is called an appeal. An *appeal* deals specifically with denial, reduction, termination, and/or suspension of the medical necessity for a service or treatment that is a benefit or for the denial of a claim for services

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

Acquired brain injury means a neurological insult to the brain, which is not hereditary, congenital or degenerative. The *injury* to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition or psychosocial behavior.

Attending physician means the *physician* responsible for the care of a patient or the *physician* supervising the care of patients by residents, or medical students.

Autism spectrum disorder means a neurological and developmental disorder that begins early in childhood and lasts throughout a person's life. It is a condition related to brain development that impacts how a person perceives and socializes with others, causing problems in social interaction and communication. It may include intellectual impairment but not always. The disorder may include problems with the ability to recognize or share interests or emotional experiences, problems expressing or understanding verbal or non-verbal communication, and/or developing or maintaining relationships. Repetitive patterns of behavior or an inability to tolerate change is often seen.

Authorization or ***Authorized*** (also *prior authorization* or Approval) means our decision to approve the medical necessity or the appropriateness of care for an enrollee by the enrollee's *PCP* or provider. Authorizations are not a guarantee of payment. "*Prior authorization*" includes prospective or *utilization review* procedures conducted prior to providing a health care service, device, or drug.

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

- 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*;
- A person *authorized* by law to provide substituted consent for a covered individual; or
- 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 expense*. *Network provider*s may not balance bill you for *covered service* expenses beyond your applicable *cost sharing* amounts.

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

Behavioral health is a state of an individual's well-being. It is a continuum of prevention, intervention, treatment and recovery support services for mental health and *substance use disorder*. *services*

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

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

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

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of *medically necessary* transplant 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.*

Child Health Supervision Services means *physician*-delivered or *physician*-supervised services that include the services described in the Major Medical Expense section of this *contract.* These services do not include *hospital* charges.

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

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

Complaint means any expression of dissatisfaction by you, including dissatisfaction with the administration, claims practices or provision of services, which relates to the quality of care provided by a *provider* pursuant to our *contract* and which is submitted to us or to a state agency. A *complaint* is part of the informal steps of a *grievance* procedure and is not part of the formal steps of a *grievance* procedure unless it is a *grievance* as defined in this section. Examples include but not limited:

- Care received from a provider
- Service received from a provider
- How long it takes to get an appointment
- How you were treated
- Service that is not included as an Ambetter from Sunshine Health benefit
- How a bill was paid
- How you were treated by Ambetter from Sunshine Health staff.

Complications of pregnancy means:

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

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

Contract when *italicized,* refers to this *contract* as issued and delivered to you. It includes the attached pages, including your *Schedule of Benefits* and any amendments.

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

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

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

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

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

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

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

Custodial care means 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, educational care or recreational care.

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

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

Dependent member means the primary subscriber's lawful spouse, domestic partner or an *eligible child*. Each *dependent member* must either be named in the enrollment application or we must agree in writing to add them as a *dependent member*.

Drug discount, coupon or ***copayment card or manufacturer supplied prepaid credit card*** means cards or *coupons* typically provided by a drug manufacturer. The card/*coupons* discount the *copay* or your other out-of-pocket costs (e.g., *deductible* or *maximum out-of-pocket amount*) to acquire a medication.

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

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

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

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

4. A child for whom legal guardianship has been awarded to you or your *spouse,* or domestic partner. It is your responsibility to notify us if your child ceases to be an *eligible child*. You must reimburse us for any benefits that we provide or pay for a child at a time when the child did not qualify as an *eligible child*;
5. A child from the first of the month following the month in which the child turns age twenty-six (26) until the end of the calendar year in which the child turns thirty (30) years of age; and who is a resident of Florida or a full-time or part-time student; and is not provided coverage as a named *member* under any other group or individual health benefit plan; or is not entitled to benefits under Title XVIII of the Social Security Act.
6. A foster child placed in your custody;

If a dependent child is provided coverage under the *contract* after the child reaches age twenty-six (26) and the coverage for the child is subsequently terminated prior to the end of the calendar year in which the child turns age thirty (30), the child is ineligible to be covered again under the *contract* unless the child was continuously covered by other creditable coverage without a coverage gap of more than sixty-three (63) days.

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

1. For *network providers*: When a *covered service* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.
2. For *non-network providers,* unless otherwise required by Federal or Florida law, the *eligible expense* is as follows:
    a. When a covered *emergency* service is received from a *non-network provider* as a result of an *emergency* within Florida, the eligible 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 the greatest of the following:
        i. the verifiable median contracted amount paid by all eligible insurers for the same or similar services, calculated by a vendor utilized and chosen by the Florida Office of the Insurance Commissioner,
        ii. the most recent verifiable amount agreed to us and the *non-network provider* who rendered the *emergency services* for the same service during which time that provider was *network* with us (if applicable), or
        iii. a higher amount that we may deem appropriate given the complexity and circumstances of the services provided by the provider.

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

    b. When a covered *emergency* service is received from a *non-network provider* outside of Florida, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full. If the provider has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by applicable law, the eligible service expense is reimbursement as determined by us and as required by applicable law. *Member* cost share will be calculated from the recognized amount based upon federal law. You should not be balance billed for the difference between the amount we pay and the provider's charges, but you may be subject to cost-sharing obligations. If you are balance billed in these situations, please contact *Member* Services immediately at the number listed on the back of your *member* identification card.
    c. When a *covered service* is received from a *non-network* professional provider who renders non-

emergency services at a *network* facility, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full. If the provider has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by applicable law, the *eligible expense* shall be the lesser of: (1) the provider's billed charges, (2) the *usual and customary* provider charges for similar services in the community where the services were provided, or (3) the charge mutually agreed to by us and the provider within 60 days of the submittal of the claim. You will not be balance billed for the difference between the amount we pay and the provider's charges, but you may be subject to cost-sharing obligations. If you are balance billed in these situations, please contact *Member* Services immediately at the number listed on the back of your *member* identification card.

d. For all other *covered service*s received from a *non-network provider* for which any needed authorization is received by us, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the *non-network provider* as payment in full (you will not be billed for the difference between the negotiated fee and the provider's charge). If there is no negotiated fee agreed to by the *non-network provider* with us, the *eligible expense* is the greatest of the following: (1) the amount that would be paid under Medicare for the *covered service*; (2) the amount for the *covered service* calculated using the same method we generally use to determine payments for *non-network providers*; or (3) the contracted amount paid to *network providers* for the *covered service* (if there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts). In addition to applicable cost-sharing, you may be balance billed for these services.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another *hospital* prior to delivery;
2. That a transfer may pose a threat to the health and safety of the patient or fetus; or
3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

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

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

Emergency services and care shall mean medical screening, examination, and evaluation by a *physician*, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a *physician*, to determine if any *emergency medical condition* exists and, if it does, the care, treatment, or *surgery* for a *covered service* by a *physician* necessary to relieve or eliminate the *emergency medical condition*, within the service capability of a *hospital*.
Follow-up care is not considered *emergency care*. Benefits are provided for treatment of *emergency medical conditions* and *emergency* screening and stabilization services without *prior authorization*. Benefits for *emergency care* include facility costs and *physician* services, and supplies and *prescription drugs*

charged by that facility. You must notify us or verify that your *physician* has notified us of your admission to a *hospital* within 48 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the *inpatient* setting is appropriate, and if appropriate, the number of days considered *medically necessary.* By contacting us, you may avoid financial responsibility for any *inpatient* care that is determined to be not *medically necessary* under your plan. If your provider does not contract with us, you will be financially responsible for any care we determine is not *medically necessary*. Care and treatment provided once you are *medically stabilized* is no longer considered *emergency* care. Continuation of care from a non-*network* provider beyond what is needed to evaluate or stabilize your condition in an *emergency* will be covered as a non-*network* service unless we *authorize* the continuation of care and it is *medically necessary*.

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

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

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

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

Items (3) and (4) above do not apply to phase I, II, III or IV *FDA* 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*, *skilled nursing facility* or *rehabilitation facility* by the state in which it operates;
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *physician* and the direct supervision of a registered nurse;
3. Maintains a daily record on each patient;
4. Has an effective *utilization review* plan;
5. Provides each patient with a planned program of observation prescribed by a *physician;* and
6. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing *generally accepted standards of medical practice* for that condition.

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

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

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

Grievance means a *complaint* submitted by or on behalf of a *member* to us or a state agency regarding the:

- Availability, coverage for the delivery, or quality of health care services including a *complaint* regarding an *adverse determination* made pursuant to *utilization review*;
- Claims payment, handling or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between a *subscriber* and us.

A *grievance* does not include a written *complaint* submitted by or on behalf of a *member* eligible for a *grievance* and *appeals* procedure provided by us pursuant to contract with the Federal Government under Title XVIII of the Social Security Act.

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

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

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

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

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

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

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

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

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

Hospital means an institution that:

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

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

This includes services of an osteopathic *hospital* when services are available in the *service area.*

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, domestic partner, *eligible child*, or siblings of a member, residing with a member

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

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

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

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

Long-term Acute Care *means services that specialize in treating critically ill patients, including those dependent on ventilators for life support, patients with complex wounds and patients with multiple organ system failure who require extended treatment in hospital settings*

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

Managed drug limitations means limits in coverage based upon time period, amount or dose of a drug, quantity limits, age or gender limitations, requirements for previously tried and failed drugs or other specified predetermined criteria.

Maximum out-of-pocket amount means the sum of the *deductible amount*, *prescription drug deductible amount* (if applicable), *copayment amount* and *coinsurance percentage* of *covered expenses*, as shown in your *Schedule of Benefits*.

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

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

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

Medically stabilized for non-*Emergency Services* means that the person is no longer experiencing further deterioration as a result of a prior *injury* or *illness* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*. Stabilize, with respect to an *Emergency Medical Condition*, means to provide medical treatment of the condition as necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer* to a *Network* Facility or discharge of the individual from a Facility, (*See Ambulance Service Benefits provision under the Major Medical Expense Benefits section).

Member means an individual covered by the health plan including an enrollee, subscriber, or policyholder. A *member* must either be named in the enrollment application or we must agree in writing to add them as a *dependent member*.

Mental health disorder means a condition that causes disturbance in behavior, emotion and cognition. These disorders can vary in impact, ranging from no impairment to mild, moderate or severe impairment. Depending on the severity, they may be accompanied by significant distress that affects an individual's work, school and social relationships. *Mental health disorder* benefits are defined as benefits for items or services for mental health conditions listed in ICD-10 Chapter 5 (F), except for subchapter 1 (F01-09) and subchapter 8 (F70-79).

Minimum essential coverage means any health insurance plan that meets the Affordable Care Act (ACA) requirement(s) for health insurance coverage. Examples include, job-based plans, Health Insurance Marketplace ("Marketplace") plans, most individual plans sold outside of the Marketplace, Medicare, Medicaid, Children Health Insurance Program (CHIP), TRICARE, COBRA and plans sold through the Small Business Health Insurance Program (SHOP) Marketplace.

Necessary medical supplies means medical supplies that are:

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

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

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

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

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

Orthotic device means a *medically necessary* device used to support, align, prevent or correct deformities, protect a body function, improve the function and moveable body part or assist with dysfunctional joints. Orthotics must be used 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 *contract* 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, workers compensation policy, 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

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

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

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

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

Pre-service claim means any claim for benefits for medical care or treatment that has not yet been provided and requires the approval by us 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 FDA approved medicinal substance whose label is required to bear the legend "RX only.

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

Primary care physician (PCP) means *a provider* who gives or directs health care services for you. PCPs include internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), *Physician* Assistants (PA), obstetrician gynecologist (ob-gyn) and pediatricians or any other

practice allowed by the plan. A PCP supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

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

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

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

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

Qualified individual means, an individual who has been determined eligible to enroll in a *health plan* in the individual market.

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

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

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

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

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

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

Rehabilitation therapy means therapy to help a person regain abilities that have been lost or impaired as a result of disease, *injury* or treatment. It is provided to optimize functioning and reduce disability in individuals. Types of *rehabilitation therapy* include physical therapy, occupational therapy, speech therapy, cardiac therapy and respiratory therapy. It may occur in either an outpatient or *inpatient* setting.

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

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

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

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

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

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

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

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

Skilled nursing facility means services that include *physician* services, room and board limited to semi-private rooms, unless a private room is *medically necessary* or a semi-private room is not available, and patient meals, general nursing care, rehabilitative services, drugs (drugs and biologicals), medical supplies and the use of appliances and equipment furnished by *skilled nursing facility*. Limitations apply, see your *Schedule of Benefits*.

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

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

Spouse means the person to whom you are lawfully married.

Step-therapy protocol means a written protocol that specifies the order in which certain *prescription drugs*, medical procedures, or courses of treatment must be used to treat a member's condition.

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

Subscriber means the primary individual who applied for this insurance policy.

Substance use disorder means a disorder that affects a person's brain and behavior, leading to an inability to control his/her use of substances (e.g., alcohol, medications and legal or illegal drugs). Symptoms can range from moderate to severe, with addiction being the most severe form of a *substance use disorder*. *Substance use disorder* benefits are defined as benefits for items or services for *substance use disorder* conditions listed in ICD 10 Chapter 5 (F), except for subchapter 1 (F01-09) and subchapter 8 (F70-79)

Surgery or ***surgical procedure*** means:

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

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

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

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

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

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

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

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

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

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

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

Urgent grievance means a *grievance* involving a situation that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.

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

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

Usual and customary means the fair market value of the service provided (i.e. what a willing buyer will pay and a willing seller will accept in an arm's-length transaction). In determining the fair market value of the service provided, we consider, among other things, the amounts reasonably accepted by providers, when available, for the service or similar services in the geographical area in which the service was received.

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

DEPENDENT MEMBER COVERAGE

Dependent Member Eligibility

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

1. The date you became covered under this *contract;* or
2. The date of marriage to add a *spouse*; or
3. The date of an eligible newborn's birth; or
4. The date that an adopted child is placed with you or your *spouse* for the purposes of adoption or you or your *spouse* assumes total or partial financial support of the child.
5. The date a foster child is placed in your custody; or
6. The date a domestic partnership is established, pursuant to state law.

Effective Date for Initial Dependent Members

Only *dependents* included in the initial enrollment application for this *contract* will be covered on your *effective date*.

Coverage for a Newborn Child

An *eligible child* born to you or your covered family member(s) 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 your *Schedule of Benefits*.

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

Coverage for an Adopted Child

Coverage for children under this *contract* will be provided for the adopted child of a *member* who has family coverage. Coverage is provided from the moment of placement to a child the *member* proposes to adopt who is placed in the *member's residence* in compliance with Chapter 63, Florida Statues. A newborn infant who is adopted by the *member* is covered from the moment of birth if a written agreement to adopt such child has been entered into prior to the birth of the child, whether or not such agreement is enforceable. However, coverage will not be provided in the event the child is not ultimately placed in the *member's residence* in compliance with chapter 63, Florida Statutes.

The *member's* adopted child is covered from the moment of placement in the *residence*, or if a newborn, from the moment of birth, if the child is enrolled timely as specified in the Special and Limited Enrollment Period provision.

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child and we have received notification from you. 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 you within 60 days of the birth or placement and b) any additional premium required for the addition of the child within 90 days of the date of *placement.*

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

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

Adding Other Dependent Members

If you apply in writing to add a *dependent member* and you pay the required premiums, we will send you written confirmation of the added *dependent member's effective date* of coverage and *member* identification Cards for the added *dependent member.*

ONGOING ELIGIBILITY

For All *Members*

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

1. The date that a *member* 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*; or
2. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact ; or
3. The date we receive a request from you to terminate this *contract*, or any later date stated in your request; or
4. The date we decline to renew this *contract,* as stated in the Discontinuance provision; or
5. The date of *a member's* death.
6. The *subscriber* residing outside the *service area* or moving permanently outside the *service area* of this policy; or

If you have material modifications (examples include a change in life event such as marriage, death, or other change in family status), or questions related to your health insurance coverage, contact us or you can log onto your Ambetter *member* portal to process these changes. You can log onto your consumer dashboard at member.ambetterhealth.com to process these changes. If you enrolled through Ambetter contact *Member* Services at 1-877-687-1169 (Relay FL 1-800-955-8770).

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 a dependent child reaching the limiting age of 26, coverage under this *contract* will terminate the thirty-first (31st) day of December the year that the dependent turns 30 years of age.

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

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

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

If health benefits are denied for the stated reason that the child has reached the limiting age for dependent coverage specified in this *contract*, the *member* has the burden of establishing that the child continues to meet the criteria specified above. Failure to provide the required proof may result in the dependent's termination of coverage.

The coverage of the disabled child may be continued, but not beyond the termination date of such incapacity or such dependence. This provision shall in no event limit the application of any other *contract* provisions terminating such child's coverage for any other reason than the attainment of the limiting age. If you have material modifications (examples include a change in life event such as marriage, death or other change in family status) you can log onto your consumer dashboard at member.ambetterhealth.com to process these changes.

Prior Coverage

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

If there is no prior coverage or no continuation of *inpatient* coverage after the *effective date*, your Ambetter coverage will apply for *covered service*s 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-network hospital*, claims will be paid at the Ambetter allowable until you are discharged or no longer eligible for benefits and you may be billed for any balance of costs above the Ambetter allowable.

Out of Service Area *Dependent Member* Coverage

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

Open Enrollment

Each year there will be an open enrollment period for coverage. The open enrollment period begins November 1, 2022, and extends through January 15, 2023. If you enroll on or before December 15, 2022, will have an *effective date* of coverage on January 1, 2023.

Special and Limited Enrollment

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

Qualifying events include:

1. A *qualified individual* or *dependent* experiences a loss of *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;
    a. In the case of marriage, at least one *spouse* must demonstrate having *minimum essential coverage* as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage.
3. A *qualified individual's* enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or its instrumentalities as evaluated and are determined by the applicable state authority or *us*;
4. An enrollee or *dependent* adequately demonstrates to the applicable state authority *us* that the plan in which he or she is enrolled substantially violated a material provision of its *contract* in relation to the enrollee;
5. A *qualified individual*, enrollee, or *dependent* gains access to new QHPs as a result of a permanent move, and had *minimum essential coverage* as described in 26 CFR 1.5000A–1(b) for one or more days during the sixty days preceding the date of the permanent move;

6. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
7. A *qualified individual*, enrollee, or *dependent* is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B–2, and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
8. A *qualified individual* or *dependent* is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 days after the qualifying event; or applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;
9. A *qualified individual* newly gains access to an employer sponsored Individual Coverage Health Reimbursement Arrangement (ICHRA) (as defined in 45 CFR 146.123(b)) or a Qualified Small Employer Health Reimbursement Arrangement (QSHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code);
10. A *qualified individual* or *dependent* is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions or government subsidies completely cease.

If *you* have or believe *you* have experienced a qualifying event (common examples include a change in life event such as marriage, death, or other change in family status), contact *Member* Services at 1-833-510-4727 (Relay 711).

PREMIUMS

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

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

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

When a *member* is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 60 day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *contract* will stay in force. 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
We require each *contract* holder to pay his or her premiums and this is communicated on your monthly billing statements. Our payment policies were developed based on guidance from the Centers for Medicare and Medicaid Services (CMS) recommendations against accepting *third party* premiums. Consistent with CMS guidance, the following are the ONLY acceptable third parties who may pay Ambetter premiums on your behalf:

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

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

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 Residenc*e*

If you change your *residence*, you must notify us, or log into your Ambetter *member* portal to process your changes 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 provision 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* enrollment application for coverage under this *contract,* we have the right to rerate the *contract* back to the original *effective date*.

COST SHARING FEATURES

Cost Sharing Features

Ambetter may review your service selections and at our option we may offer rebate(s) when we determine higher quality and lower costs, evidence based selection(s) were actively chosen by you. We will pay benefits for *covered services* as described in your *Schedule of Benefits* and the Major Medical Expense Benefits section of this *contract.* Benefits we pay will be subject to all conditions, limitations, and *cost sharing* features of this *contract*. *Cost sharing* means that you participate or share in the cost of your healthcare services by paying *deductible amounts*, *copayments* and *coinsurance* for some *covered services.* For example, you may need to pay a deductible, *copayment,* or *coinsurance* amount when you visit your *physician* or are admitted into the *hospital*. The *copayment* or *coinsurance* required for each type of service as well as your *deductible* is listed in your *Schedule of Benefits*.

When you, or a covered dependent, receive health care services from a provider, there may be multiple claims for that episode of care. An episode of care means the services provided by a 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 expenses*. Each claim received will be processed separately according to the *cost share* as outlined in the *contract* and in your *Schedule of Benefits.*

Deductible

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

Copayments

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

Coinsurance Amount

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

Maximum Out-of-Pocket

You must pay any required *copayment*s or *coinsurance amounts* required until you reach the *maximum out-of-pocket amount* shown in your *Schedule of Benefits*. After the *maximum out-of-pocket amount* is met for an individual, we will pay 100 percent 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 expenses*.

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

The amount provided or payable will be subject to:

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

The applicable *deductible amount(s), coinsurance,* and *copayment amounts* are shown on your *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*, *copayment amount*, and *coinsurance*, you are responsible for the difference between the *eligible expense* and the amount the *non-network provider* bills you for the services or supplies. Any amount you are obligated to pay to the *non-network provider* in excess of the *eligible expense* will not apply to your *deductible amount* or *maximum out-of-pocket amount*.

ACCESS TO CARE

Primary care physician

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

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

*If you choose a nurse practitioner as your *PCP*, your benefit coverage and *copayment amounts* are the same as they would be for services from other in-*network providers*. See your *Schedule of Benefits* for more information You may obtain a list of *network primary care physicians* at our website and using the "Find a Provider" function or by contacting our *Member* Services department.

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

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

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

Contacting Your Primary Care Physician

To make an appointment with your *PCP*, call his/her office during business hours and set up a date and time. If you need help, call *Member* Services at 1-877-617-0390 and we will help you make the appointment. If you need to cancel or change your appointment, call 24 hours in advance. At every appointment, make sure you bring your *member* identification card and a photo identification.

Should you need care outside of your *PCP's* office hours, you should call your *PCP's* office for information on receiving after hours care in your area. If you have an urgent medical problem or question or cannot reach your *PCP* during normal office hours, call our 24/7 nurse advice line at 1-855-604-1303 (Relay FL 1-800-955-8770). 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.

*Ambetter Telehealth** is our free 24-hour access to in-*network* Ambetter healthcare providers when you have a non-*emergency* health issue. It is available to use when you are at home, in the office or even on vacation. Before you start using *Ambetter Telehealth*, you will need to set up your account at AmbetterTelehealthFL.com.

*Ambetter does not provide medical care. Medical care is provided by individual providers. $0 Telehealth *copay* does not apply to plans with HSA until the *deductible* is met

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

Network Availability
The *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 or as soon as possible. Note that *covered services* from *non-network providers* are not *covered service*s under this agreement but you may have the opportunity to disenroll from coverage under this *contract* and enroll in a different health plan with a *network* in that area. If you receive non-*emergency services* from *non-network providers*, benefits will be calculated in accordance with the terms of this *contract* for *non-network providers*.

Coverage Under Other *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 *contract.*

Non-Emergency Services
If you are traveling outside of the Florida 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 Florida 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 *member* identification card for further information.

***Emergency Services* Outside of Service Area**
We cover *emergency* care services when you are outside of our *service area*.

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

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

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

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

Sometimes, our medical director and/or medical management staff will identify technological advances that could benefit our *members*. The Clinical *Contract* 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.

Preferred Partnership
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.*

Hospital Based Providers
When receiving care at an Ambetter participating *hospital* it is possible that some hospital-based providers (for example, assistant surgeons, hospitalists, and intensivists) may not be under contract with Ambetter as participating providers. 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 – 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. Any amount you are obligated to pay to the nonparticipating provider in excess of the *eligible expense* will not apply to your *deductible amount* or maximum out-of-pocket.

You may not be balanced 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.

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

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

MAJOR MEDICAL EXPENSE BENEFITS

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

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

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 ground and water transportation, transportation from home, scene of accident, or medical *emergency*

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

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

Note: non-*emergency* ambulance transportation requires *prior authorization*. Unless otherwise required by Federal or Florida law, if you receive services from *non-network* ambulance providers, you may be responsible for costs above the *allowed amount*.

Exclusions:
No benefits will be paid for:
1. Expenses incurred for ambulance services covered by a local government or municipal body, unless required by law.
2. Ambulance services provided for a member's comfort and convenience.
3. Non-*emergency* transportation excluding ambulances (for example-transport van, taxi).

Air Ambulance Service Benefits

Covered service expenses will include ambulance services for ground, water, transportation by fixed wing and rotary wing air ambulance 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 Sunshine Health.
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 *emergency* air ambulance services.

We will provide reasonable reimbursement to an air ambulance service for covered non-*emergency* and *emergency services* provided to you in accordance with the coverage terms of this *contract*. In this context, "reasonable reimbursement" means reimbursement that considers the direct cost to provide the air ambulance transportation service to you, the operation of an air ambulance service by a county, which operates entirely within a designated area of critical state concern as determined by the Department of Economic Opportunity, and in-*network* reimbursement established by us under this *contract*. The term "reasonable reimbursement" does not include the *billed amount*.

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. Air Ambulance services provided for a member's comfort or convenience.
5. Non-*emergency* transportation excluding ambulances.

Mental Health and *Substance Use Disorder* Benefits

The coverage described below is designed 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 mental health conditions. These conditions affect the individual'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 a *network behavioral health providers* by using our Find a Provider tool at Ambetter.SunshineHealth.com or by calling *Member* Services at 1-877-687-1169 Relay FL 1-800-955-8770). *Deductible amounts*, *copayment amount* or *coinsurance amounts* and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

Covered services for mental health and *Substance use disorder* are included on a non-discriminatory basis for all *Members* for the diagnosis and *Medically necessary* treatment of mental, emotional, or *Substance use disorder*s as defined in this *contract*.

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

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

Inpatient

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

Outpatient

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

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

In addition, Integrated *Care Management* is available for all of your healthcare needs, including *behavioral health* and *substance use disorder*. Please call 1-877-687-1169 (Relay FL 1-800-955-8770) to be referred to a care manager for an assessment.

Expenses for these services are covered if *Medically necessary* and may be subject to *Prior authorization*. However, we will not require *prior authorization* for withdrawal management services or *Inpatient* or residential *Substance use disorder* treatment services. Please see the *Schedule of Benefits* for more information regarding services that require *prior authorization* and specific benefit limits, if any

Autism Spectrum Disorder Benefits

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

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

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

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

See your *Schedule of Benefits* for benefit levels.

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

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

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

5. Outpatient physical therapy, occupational therapy, respiratory, pulmonary or inhalation therapy and speech therapy.

Custodial care services are not covered under this *contract*, See your *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 meaningful measurable progress toward documented goals.
4. Care is primarily *custodial care*.

Home Health Care **Service Expense Benefits**

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

1. *Home health aide services,* only if provided in conjunction with a *physician medically necessary* skill order that must be provided by a skilled registered nurse or licensed practical nursing services. Skilled services of a registered nurse or licensed practical nurse rendered on an outpatient basis.
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.* Please refer to your *Schedule of Benefits* for any limits associated with this benefit.
3. Intravenous medication and pain medication.
4. Hemodialysis, and for the processing and administration of blood or blood components.
5. *Necessary medical supplies*.
6. Rental or purchase of *medically necessary durable medical equipment at the discretion of the plan.* At *our* option, we may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider we authorize before the purchase.

Intravenous medication and pain medication are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

Limitations:
See your *Schedule of Benefits* for benefit levels or additional limits for expenses related to *home health aide services*. *Home health care* services not in conjunction with a registered or licensed practical nurse and *home health aide* are not covered.

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

Hospice **Care Service Expense Benefits**

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

1. Room and board in a *hospice* while the *member* is an *inpatient.*
2. Occupational therapy.
3. Speech-language therapy.

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

Benefits for *hospice inpatient*, home or outpatient care are available for one continuous period up to one hundred eighty (180) days in a *covered person*'s lifetime.

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

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

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

Second Medical Opinion
Members are entitled to a second medical opinion under the following conditions:
1. Whenever a *surgical procedure* is recommended to confirm the need for the procedure;
2. Whenever a serious *injury* or *illness* exists; or
3. Whenever you feel that you are not responding to the current treatment plan in a satisfactory manner.

If requested, the second opinion consultation is to be provided by a *physician* of the *member's* choice. The *member* must select a *network provider* listed in the Ambetter from Sunshine Health 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 or diagnostic and therapeutic services are subject to the additional *cost sharing.* The plan may allow a second opinion from a *non-network provider* which will be subject to *prior authorization* and medical necessity review, and the *non-network provider* has to agree to payment rates

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

a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
b. Daily room and board and nursing services while confined in an *intensive care unit*.
c. *Inpatient* use of an operating, treatment, or recovery room.
d. Outpatient use of an operating, treatment, or recovery room for *surgery.*
e. Services and supplies, including drugs and medicines, which are routinely provided by the *hospital* for use only while you are *inpatient.*
f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required.

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, seven days a week.

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

Medical and Surgical Expense Benefits
Covered service expenses are limited to charges:

1. For *surgery* in a *physician's* office or *outpatient surgical facility,* including services and supplies.
2. For the professional services of a *medical practitioner,* including *surgery*
3. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
4. For diagnostic testing using radiologic, ultra-sonographic, or laboratory services.
5. For chemotherapy and radiation therapy or treatment.
6. For hemodialysis and the charges by a *hospital* or dialysis center for processing and administration of blood or blood components.
7. For the cost and administration of an anesthetic.
8. For accidental dental treatment in a *hospital* or ambulatory surgical center. Benefits are available for general anesthesia and hospitalization services in connection with necessary dental treatment or *surgery*, subject to *prior authorization* by us.
    a. A *member* under age eight (8) whose treating health care professional, in consultation with the dentist, determines the child has a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or
    b. A *member* who has one (1) or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any dental treatment or *surgery* if not rendered in a *hospital* or ambulatory surgical center.

Necessary dental treatment is that which, if left untreated, is likely to result in a medical condition. Use of general anesthesia in a *hospital* or ambulatory surgical center is subject to *prior authorization* by us. Please call *Member* Services to confirm your benefits for the use of general anesthesia in a *hospital* or ambulatory surgical center.

9. For oxygen and its administration.
10. For dental service expenses when a *member* suffers an *injury*, after the *member's effective date* of coverage, that results in:
    a. Damage to his or her sound natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the sound natural teeth will not include any *injury* as a result of chewing.
11. For *surgery*, excluding tooth removal, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See your *Schedule of Benefits* for benefit levels or additional limits.
12. For reconstructive breast *surgery* charges as a result of a partial or total mastectomy. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas. Coverage for outpatient post-surgical care is provided in the most medically appropriate setting which may include a *hospital*, treating *physician's* office, outpatient center or the *member's* home. *Inpatient hospital* treatment for mastectomy will not be limited to any period that is less than that recommended by the *attending physician*.
13. For *medically necessary chiropractic care* treatment on an outpatient basis only. See your *Schedule of Benefits* for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the policy, including the *deductible amount* and cost sharing provisions.
14. *Covered service expenses* are permitted when a *member* receives services from a *network provider* specializing in obstetrics and gynecology for obstetrical or gynecological care or if *medically necessary* follow-up care is detected at the visit without a referral from *the member's primary care physician*.
15. For the following types of tissue transplants:
    a. Cornea transplants;
    b. Artery or vein grafts;
    c. Heart valve grafts;
    d. Prosthetic tissue replacement, including joint replacements; and
    e. Implantable prosthetic lenses, in connection with cataracts.
16. Family Planning for certain professional provider contraceptive services and supplies, including but not limited to sterilization and vasectomies, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.
17. *Covered services* for *medically necessary* diagnosis and treatment of osteoporosis for high-risk *member*, including, but not limited to, estrogen-deficient *members* who are at clinical risk for osteoporosis, *members* who have vertebral abnormalities, individuals who are receiving long-term hyperparathyroidism and *members* who have a family history of osteoporosis.
18. Cleft lip and cleft palate for an *eligible child* under the age of 18. *Covered services* includes medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the treating *physician* or surgeon and such *physician* or surgeon certifies that such services are *medically necessary* and consequent to treatment of the cleft lip or cleft palate.
19. For Dermatology services which are limited to the following: *Medically necessary* minor *surgery*, tests, and office visits provided by a dermatologist who is a *network provider*.
20. Mammograms as follows: (a) A baseline mammogram for any *covered person* who is 35 to 40 years of age; (b) A mammogram every 2 years for any *covered person* who is 40 to 50 years of age, or

older, or more frequently based on the patient's *physician's* recommendations; (c) A mammogram every year for any *covered person* who is 50 years of age or older; (d) A mammogram based upon a *physician's* recommendation for any *covered person* who is at risk for breast cancer because of personal medical history, genetic history, or family history of breast cancer. (e) Mammogram surveillance for breast cancer patients. (f) Diagnostic mammogram after abnormal screening mammogram. For *medically necessary* genetic blood tests.

21. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
22. For *medically necessary* allergy treatment including allergy injection.
23. Coverage for *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis;
24. *Medically necessary telehealth services* subject to the same clinical and *utilization review* criteria, plan requirements and limitations as the same health care services when delivered to an insured in person. *Telehealth services* provided by *Ambetter Telehealth* Vendors are subject to $0 copay. *Telehealth services* not provided by *Ambetter Telehealth* Vendors would be subject to the same cost sharing as the same health care services when delivered to an insured in-person. Pursuant to federal regulation, the $0 cost share does not apply to *members* enrolled in an HSA-eligible plan. Please review your *Schedule of Benefits* to determine if your plan is HSA-eligible.
25. *Medically necessary* services made by a provider who renders services in a *network urgent care center*, including facility costs and supplies.
26. 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.
27. For pulse oximetry screening on a newborn
28. 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.
29. Newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification
30. Allergy testing, injections and serum 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;
31. Wigs (not to exceed one per calendar year) when purchased through a network provider. This coverage is only provided for *members* who suffer from hair loss as a result of an underlying medical condition, treatment or injury. Coverage shall be subject to a written recommendation by the treating physician stating that the wig is *medically necessary*
32. 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;
33. 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.
34. 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 8
b. a person who is severely

35. 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.
36. Testing of pregnant women and other *members* for lead poisoning.
37. *Medically necessary* routine foot care, prior authorization may be required
38. *Medically necessary* nutritional counseling, prior authorization may be required

Diabetic Care

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

Insulin

The total amount you will be required to pay for a covered insulin drug will not exceed any state and/or federal mandated limits.

Dialysis Services

Medically necessary acute and chronic dialysis services are *covered service*s 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 a *network* dialysis Facility or peritoneal dialysis in your home from a *network provider* when you qualify for home dialysis.

Covered expenses include:

1. Services provided in an Outpatient Dialysis Facility or when services are provided in the Home;
2. Processing and administration of blood or blood components;
3. Dialysis services provided in a *hospital*;
4. 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.

Outpatient Medical Supplies Expense Benefits

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

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs (but not the replacement thereof, unless required by a physical change in the *covered person* and the item cannot be modified). If more than one *prosthetic device* can meet a *covered person's* functional needs, only the charge for the most cost effective *prosthetic device* will be considered a *covered expense*.

2. For one pair of foot orthotics per year per *covered person*.
3. For the purchase or rental of *medically necessary durable medical equipment*.
4. For the rental of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint *surgery*.
5. For the cost of one wig per *covered person* necessitated by hair *loss* due to cancer treatments or traumatic burns.
6. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract *surgery*.

Durable Medical Equipment*, Medical and Surgical Supplies, Orthotic Devices and *Prosthetics

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 *allowed 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 our *habilitation* equipment *specialist* or vendor should be done to estimate the cost of repair.
3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4. The equipment, supply or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include the following:

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.

<u>*Durable medical equipment*</u>

The rental (or, at our option, the purchase) of *durable medical equipment* prescribed by a *physician* or other provider. *Durable medical equipment* is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of *illness* or *injury*; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, *hospital* beds, and oxygen equipment. Rental 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.
9. *Medically necessary* corrective footwear, prior authorization may be required

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

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

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

Covered Services may include, but are not limited to:

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

Exclusions:
Non *Covered Services* include but are not limited to:

1. Adhesive tape, band aids, cotton tipped applicators.
2. Arch supports.
3. Doughnut cushions.
4. Hot packs, ice bags.
5. Vitamins (except as provided for under Preventive Care Expense Benefits provision).
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. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
7. Restoration prosthesis (composite facial prosthesis).
8. Wigs (the first one following cancer treatment, not to exceed one per benefit period), when purchased through a *network* 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).

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

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

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

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

Exclusions:
Non-*covered services* 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 the Medical Supplies provision).
4. Garter belts or similar devices.

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 by a *physician.*

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

Medication Balance-On-Hand

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

Split-Fill Dispensing Program

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

How to Fill a Prescription

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

If you decide to have your prescription order filled at a *network* pharmacy, you can use the online Provider Directory to find a pharmacy near you. You can access the Provider Directory at Guide.SunshineHealth.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 order and your *member* identification 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 i*llnesses*, such as high blood pressure, asthma, and diabetes. You can find a list of covered medications on Ambetter.SunshineHealth.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 amount/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*," "Drug Coverage" and you will then see information of how to get medications delivered to your home or any other address you choose with no delivery fees.

Formulary or *Prescription Drug* List

The formulary or *prescription drug* list is a guide to available generic, brand name drugs and some over-the-counter medications when ordered by a *physician* that are approved by the Food and Drug Administration (FDA) and covered through your *prescription drug* benefit. Generic drugs have the same active ingredients as their brand name counterparts and should be considered the first line of treatment.

The FDA requires generics to be safe and work the same as brand name drugs. If there is no generic available, there may be more than one brand name drug to treat a condition. Preferred brand name drugs are listed on Tier 2 of the Drug List to help identify brand name drugs that are clinically appropriate, safe and cost effective treatment options, if a generic medication on the formulary is not suitable for your condition.

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

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the formulary. For the most current Ambetter Formulary or *Prescription Drug* List or for more information about our pharmacy program, visit Ambetter.SunshineHealth.com (under "For *Member*", "Drug Coverage") or call *Member* Services at 1-877-687-1169 (Relay FL 1-800-955-8770).

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 order must meet all legal requirements.

Drug Discount, Coupon, Copayment Card or Manufacturer Supplied Prepaid Credit Card

Cost sharing paid on your behalf for any *prescription drugs* with a generic equivalent will not apply toward your plan *deductible* or your *maximum out-of-pocket amount* if a *drug discount, coupon, copayment card or manufacturer supplied prepaid credit* card was used. If there is no generic version of the drug available, or if you have completed the *appeal* process or drug exception process and it has been determined that the brand name drug is the appropriate option, then any *cost sharing* paid on your behalf will count toward your *deductible* and your *maximum out-of–pocket amount*.

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 *Prescription Drug* Exception request process.

***Prescription Drug* Exception Process**

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

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

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

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

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

1. For *prescription drug* treatment of erectile dysfunction or any enhancement of sexual performance unless such treatment is listed on the formulary.
2. For weight *loss prescription drugs* unless otherwise listed on the formulary.
3. For immunization agents, blood, or blood plasma, except when used for preventive care and listed on the formulary.
4. For medication that is to be taken by the *member*, in whole or in part, at the place where it is dispensed.
5. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
6. For a refill dispensed more than 12 months from the date of a *physician's* order.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are listed 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 lock-in program.
21. For any drug related to *surrogate pregnancy*.
22. For any injectable medication or biological product that is not expected to be self-administered by the *member* at *member's* place of *residence* unless listed on the formulary.
23. Medication refills where a *member* has more than 15 days' supply of medication on hand.
24. Compound drugs, unless there is at least one ingredient that is an FDA approved drug.

25. For drugs or dosage amounts determined by Ambetter's Pharmacy and Therapy committee 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
26. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status
27. For any drug related to *surrogate* pregnancy
28. For immunization agents otherwise not required by the Affordable Care Act

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.

Lock-in Program

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

Step Therapy Protocol for Prescription Drugs

Our contract uses a requirement of Step Therapy for certain *prescription drugs*. *We* employ clinical pharmacists who review, research and analyze the efficacy and value of various drugs. Based on their reviews of clinical practice guidelines and recommended treatment of diseases, they recommend specific drugs as the first ones to try when a *member* begins or requires a change in medication therapy. For most people, these medications work well. In the limited instances where one of these medications isn't effective and/or appropriate for a particular *member*, the prescribing *physician* contacts *us* about approving coverage for a different medication. Trying medications in this "step-by-step" fashion is called Step Therapy. This also ensures that drugs are used in the appropriate clinical order for *your* medical condition.

We may provide an exception to a *step-therapy protocol* under the *contract* for a covered prescription drug requested by a *member* if:

1. The *member* has previously been approved to receive the prescription drug through the completion of a *step-therapy protocol* required by a separate health coverage plan; and
2. The *member* provides documentation originating from the health coverage plan that approved the prescription drug indicating that the member's previous health coverage plan paid for the drug on the member's behalf during the days immediately before the request.

Prescription Drug Exception Process

Prescription drug exception process is applicable when:

1. The drug is not covered based on our formulary.
2. We are discontinuing coverage of the drug.
3. The prescription drug alternatives required to be used in accordance with a step therapy requirement:
    a. has been ineffective in the treatment; or
    b. has caused an adverse reaction or harm to a member.

Medically Necessary Vision Services
Covered services include:

1. Vision screenings to diagnose and treat a suspected disease or *injury* of the eye.
2. Vision screenings to determine the presence of refractive error.
3. *Members* who have been diagnosed with diabetes may self-refer once each year to an eye care *specialist* within their network, for the purpose of receiving an eye examination for the detection of eye disease. Continued, or follow-up care from the eye care *specialist* may require a referral through your *primary care physician*.

Vision Services under the medical portion of your health plan do not include:

1. Referrals to a *specialist* for evaluation and diagnosis of refractive error, including presbyopia, for *members* over the age of 19 years.
2. Eye examinations required by an employer or as a condition of employment.
3. Radial keratotomy, LASIK and other refractive eye surgery.
4. Services or materials provided as a result of any workers' compensation law or required by any governmental agency.
5. Orthoptics, vision training or subnormal vision aids.

If you have elected additional Adult Vision Benefits, please refer to the Adult Vision Benefits sections of this *contract*.

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 examination
   a. Refraction;
   b. Dilation;
2. Contact lens fitting, Standard 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.SunshineHealth.com or call *Member* Services.

Services not covered:
1. Visual therapy;
2. Two pair of glasses as a substitute for bifocals;
3. Frame/Frame upgrade
4. Lasik *surgery*, and/or Radial Keratotomy

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 examination
    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.SunshineHealth.com or call *Member* Services.

Services not covered:
1. Visual therapy;
2. Low vision services and hardware for adults; and
3. Lasik *surgery*, and/or Radial Keratotomy

For additional information about covered vision services, participating vision vendor providers*,* call *Member* Services at 1 877-687-1169 (Relay FL 1-800-955-8770).

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 jawbone and is *medically necessary* to attain functional capacity of the affected part.
c. Oral/surgical correction of accidental injuries.
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 8;
    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.

If you purchased the adult dental rider, please refer to the adult dental covered benefits section.

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 provider.

1. Preventive and Diagnostic - Class 1 benefits include:
    a. Routine cleanings;
    b. Oral examinations;
    c. X-rays – bite-wing, full-mouth and panoramic film;
    d. Topical fluoride application.
2. Basic Services - Class 2 benefits include:
    a. Minor restorative – metal fillings (posterior teeth) and resin-based fillings (limited to anterior teeth);
    b. Endodontics;
    c. Periodontics – scaling, root planning, and periodontal maintenance;
    d. Simple extractions;
    e. Prosthodontics – relines, rebase, adjustment and repairs.
3. Major Services - 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.SunshineHealth.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 for non-covered procedures
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. Anesthesiologists services for non-covered procedures
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 abrasion, abfraction, or erosion, 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* counseling, nutritional counseling, or high-risk substance abuse counseling;
15. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture;
16. Any oral *surgery* that includes surgical endodontics (apicoectomy and retrograde filling);
17. Analgesia (nitrous oxide);
18. Removable unilateral dentures;
19. Temporary procedures;
20. Splinting;
21. Temporal Mandibular Joint disorder (TMJ) appliances, therapy, films and arthrograms;
22. Oral pathology laboratory charges;
23. Consultations by the treating provider and office visits;
24. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
25. Veneers (bonding of coverings to the teeth);
26. Orthodontic treatment procedures;
27. Orthognathic *surgery*;
28. Athletic mouth guards;
29. Space maintainers.
30. Services provided by an anesthesiologist;
31. Dental procedures or restorations to alter or increase vertical dimension of occlusion

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. Whether something is preventive is determined by the claim service data submitted by the provider.:

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.

2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual which includes pediatric and adult immunizations.
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 which includes well child care from birth.
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.
5. Covers without *cost sharing*:
    a. Screening for *nicotine or tobacco use*; and
    b. For those who use *nicotine or tobacco* products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
        i. Four (4) *nicotine or tobacco* cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without *prior authorization;* and
        ii. All Food and Drug Administration (FDA) approved *nicotine or tobacco* cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen per calendar year when prescribed by a health care provider without *prior authorization.*

Benefits for when billed as a preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any *deductibles* or *coinsurance* provisions, and *copayment amount*s under the *contract* when the services are provided by a *network provider*. If a service is considered diagnostic or non-preventive care, your "plan" *copayment*, *coinsurance,* and *deductible* will apply. It is important to know what type of service you are getting. If a diagnostic or non-preventive service is performed during the same healthcare visit as a preventive service, you may have *copayment amount* and *coinsurance* charges.

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

Child Health Supervision Services
The following *covered service* is provided for an *eligible child* in accordance with the Florida Child Health Assurance Act which includes *covered services* from the moment of birth to age 16 years. A waiver of the *deductible amount* applies to all *eligible expenses* for *Child Health Supervision Services*.
Child Health Supervision Services means *physician*-delivered or *physician*-supervised services. These services do not include *hospital* charges.

Child Health Supervision Services include periodic visits, which shall include:

- History
- Physical Examination
- Developmental Assessment
- Anticipatory Guidance
- Appropriate Immunizations
- Laboratory Testing

These services and periodic visits will be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

Eligible expenses for *child health supervision services* are limited to one visit payable to one provider for all the services provided at each visit.

Newborns' and Mothers' Health Protection Act Statement of Rights

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

Maternity Care

An *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require notification to us. We do not require that a *physician* or other healthcare provider obtain *prior authorization* for delivery. An *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require *prior authorization*. *Prior authorization* is required for all elective c-sections.

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

a. Outpatient and *inpatient* pre- and post-partum care including examinations, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, and childbirth classes.
b. *Physician* Home Visits and Office Services.
c. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
d. *Complications of pregnancy*.
e. *Hospital* stays for other *medically necessary* reasons associated with maternity care.
f. For medical services or supplies for maternity deliveries at home, required for medical professional or *medically necessary* treatment.

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

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 amount*, *coinsurance* percentage, *deductible* and *maximum out-of-pocket amount*), as listed in your *Schedule of Benefits*. Please refer to the *Dependent Member* Coverage section of this *contract* for details regarding Coverage for a Newborn Child/Coverage for an Adopted Child.

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

Duty to Cooperate
We do not cover services or supplies related to a *members pregnancy* when a *member* is acting as a *surrogate* and has entered into a *surrogacy arrangement*. For more information on excluded services, please see the General Non *Covered Service*s 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 Sunshine Health Plan at the *Member* Services Department, P.O. Box 459089 Fort Lauderdale, FL 33345-9089. 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 *contract*, plus interest, attorneys' fees, costs and all other remedies available to us.

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.

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

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

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

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

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

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

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

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

Social Determinants of Health Supplemental Benefits

Social determinants of health supplemental benefits and services may be offered to enrollees to remove barriers to accessing health services and improve overall health outcomes. These are benefits and services that we may make available in connection with this *contract*. The benefits and services provided may include transportation to health services, assistance with childcare, access to healthy meals, and other relevant services based on need. The benefits are available as long as coverage remains active, unless changed by us. Upon termination of coverage, the benefits are no longer available. All enrollees are eligible for the benefits upon obtaining coverage. The services are optional, and the benefits are made available at no additional cost to the enrollees. The benefits and services available at any given time are made part of this *contract* by this reference and are subject to change by us through an update to information available on our website or by contacting us. *Social determinants of health* benefits and services may be offered to enrollees through the "My Health Pays" wellness program and through our websites. Enrollees may receive notifications about available benefits and services through emails and/or 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.SunshineHealth.com or by contacting *Member* Services at 1-877-687-1196 (Relay FL 1-800-955-8770).

Transplant Services

Covered services for transplant service expenses:
Transplants are a *covered service* when a *member* is accepted as a transplant candidate and pre-*authorized* in accordance with this *contract*. *Prior authorization* must be obtained through the "*Center of Excellence*" before an evaluation for a transplant.

We may require additional information such as testing and/or treatment before determining medical necessity for the transplant benefit. *Authorization* must be obtained prior to performing any related services to the transplant *surgery*. Transplant services must meet medical criteria as set by Medical Management *contract*.

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 the enrollee's 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 there is a lapse in coverage due to non-payment of premium, no services related to transplants will be paid as a *covered service*.

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

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

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

Ancillary "*Center Of Excellence*" Service Benefits:
A *member* may obtain services in connection with a *physician*. However, if a transplant is performed in a *Center of Excellence:*

1. We will pay for the following services when the enrollee is required to travel more than 75 miles from the *residence* to the *Center of Excellence*:
2. We will pay a maximum of $10,000 per transplant service for the following services:
   a. Transportation for the *member,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence,* in the United States*.*
   b. When *member* and/or donor is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.

c. Maximum reimbursement for mileage is limited to travel to and from the *member's* home to the transplant facility, and to and from the donor's home to the transplant facility, and will be reimbursed at the current IRS mileage standard for miles driven for medical purposes.
d. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence* in the United States. We will *members* for the proof of costs directly related for transportation and lodging and any of the following approved items listed in the *member transplant reimbursement guidelines.* However, you must make the arrangements and provide the necessary paid receipts for reimbursement within 6 months of the date of service in order to be reimbursed.
e. Incurred costs related to a certified/registered service animal for the transplant enrollee and/or donor.
f. Please refer to the *member* resources page for *member* reimbursement transplant travel forms and information at Ambetter.sunshinehealth.com.

Bone Marrow Transplant Services:
Bone marrow transplant services are subject to the coverage terms related to transplant services above. In addition, we will not exclude coverage for bone marrow transplant procedures recommended by the referring *physician* and the treating *physician* under this *contract's* exclusion for *experimental* or *investigational treatment*(s) or *unproven services* if the procedure is identified in Section 59B-12.001 of the Florida Administrative Code .

Costs associated with the bone marrow donor are covered to the same extent and limitations as costs associated with the insured, except the reasonable costs of searching for the donor may be limited to *immediate family members* and the National Bone Marrow Donor Program.

Non-*Covered Service*s 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. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the *Center of Excellence*.
4. To keep a donor alive for the transplant operation, except when *authorized* through the *Center of Excellence*.
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
6. Related to transplants unauthorized through the *Center of Excellence* and is not included under this provision as a transplant.
7. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"FDA"*) regulation, regardless of whether the trial is subject to *FDA* oversight. **Note:** This exclusion does not apply to bone marrow transplants.
8. The acquisition cost for the organ or bone marrow when provided at an *authorized* facility or not obtained through the *Center of Excellence.*
9. For any transplant services and/or travel related expenses for *member* and donor when performed outside of the United States.
10. The following ancillary items listed below will not be subject to the *member* reimbursement under this *contract*:
    a. Alcohol/*tobacco*
    b. Car Rental (unless pre-approved by Case Management)

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

Organ Transplant Medication Notification

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

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

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

Urgent Care Services

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

Members are encouraged to contact their *primary care physician* for an appointment before seeking care from another provider, but *network urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *primary care physician* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-855-604-1303. The 24/7 Nurse Advice Line is available twenty-four (24)

hours a day, seven (7) days a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

Wellness and Other Program Benefits

Benefits may be available to enrollees for participating in certain programs that we may make available in connection with this *contract*. Such programs may include wellness programs, disease or *care management* programs. 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.SunshineHealth.com or by contacting *Member* Services by telephone at 1-877-687-1169 (Relay FL/TTY 1-800-955-8770). The benefits are available as long as coverage remains active, unless changed by us as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All enrollees are automatically eligible for program benefits upon obtaining coverage. The programs are optional, and the benefits are made available at no additional cost to the enrollees. The programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change by us through updates available on our website or by contacting us.

Care Management Programs

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

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

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

If you think you could benefit from our *Care Management* program, please call *Member* Services at 1-877-687-1169 (Relay FL 1-800-955-8770).

Acquired Brain Injury Services

Benefits for eligible service expenses incurred for *medically necessary* treatment of an *acquired brain injury* will be determined on the same basis as treatment for any other physical condition. Cognitive *rehabilitation therapy*, cognitive communication therapy, neurocognitive therapy and rehabilitation; neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment; neurofeedback therapy, remediation required for and related to treatment of an *acquired brain injury*, post-acute transition services and community reintegration services, including outpatient day treatment services, or any other post-acute treatment services are covered, if such services are necessary as a result of and related to an *acquired brain injury*.

Treatment for an *acquired brain injury* may be provided at a hospital, an acute or post-*acute rehabilitation* hospital, a *skilled nursing facility* or any other facility at which appropriate services or therapies may be provided. Service means the work of testing, treatment, and providing therapies to an individual with an *acquired brain injury*. Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an *acquired brain injury*.

To ensure that appropriate post-acute care treatment is provided, this plan includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:

1. Has incurred an *acquired brain injury*;
2. Has been unresponsive to treatment;
3. Is medically stable; and
4. To ensure that appropriate post-acute care treatment is provided, this plan includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered with the expectation that with the provision of these services and support, the person can return to a community-based setting, rather than reside in a facility setting.

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

PRIOR AUTHORIZATION

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

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

Prior Authorization Required

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

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

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

Prior authorization (medical and *behavioral health*) requests must be received by telephone, e-fax or provider web portal as follows:

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

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

1. For urgent concurrent reviews within 24 hours of receipt of the request.
2. For urgent pre-service reviews, within 72 hours from date of receipt of request.
3. For non-urgent pre-service reviews within 5 days but no longer than 15 days of receipt of the request.
4. For post-service or retrospective reviews within 30 calendar days of receipt of the request.

How to Obtain Prior Authorization

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

Failure to Obtain Prior Authorization

Failure to comply with the *prior authorization* requirements will result in benefits being reduced. *Network providers* cannot bill you for services for which they fail to obtain *prior authorization* as required.

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

Prior Authorization Does Not Guarantee Benefits

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

Requests for Predeterminations

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

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

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

Services from Non- Network Providers

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

Florida law requires that we provide you with the following disclosure about your health benefit plan coverage. "WARNING: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a *non-network provider* for a covered non-*emergency* service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to your *contract*'s out-of-*network* reimbursement benefit. *Non-network providers* may bill insureds for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE *COINSURANCE* OR *COPAYMENT AMOUNT*. Participating providers have agreed to accept discounted payments for services with no additional billing to you other than *coinsurance*, *copayment amount*, and *deductible amounts*. You may obtain further information about the providers who have contracted with your insurance plan by consulting your insurer's website or contacting your insurer or agent directly."

GENERAL NON-*COVERED SERVICES* AND EXCLUSIONS

No benefits will be provided or paid for:

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

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract,* except as expressly provided for under the Plan Administration clause in this *contract*.
2. For any portion of the charges that are in excess of the *eligible expense.*
3. For weight modification, or for surgical treatment of obesity, including complications resulting from weight modifications or surgical treatment and wiring of the teeth and all forms of intestinal bypass *surgery*.
4. For cosmetic breast reduction or augmentation except post-mastectomy for breast cancer and the *medically necessary* treatment of gender dysphoria.
5. For reversal of sterilization and reversal of vasectomies.
6. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
7. For expenses for television, telephone, or expenses for other persons.
8. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
9. For telephone consultations between providers, except those meeting the definition of *telehealth services,* or for failure to keep a scheduled appointment.
10. For stand-by availability of a *medical practitioner* when no treatment is rendered.
11. For *dental service expenses,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under the Medical and Surgical Expense Benefits provisions.
12. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a functional defect or birth defect in a child.
13. Mental Health Services are excluded:
    a. for evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless a plan provider determines such evaluation to be *medically necessary*;

b. when ordered by the court, to be used in a court proceeding, or as a condition of a parole or probation, unless a plan provider determines such services to be *medically necessary*;
c. Court ordered care or testing or required as a condition of parole or probation. Benefits will be allowed for services that are *medically necessary* and would otherwise be covered under this *contract*;
d. services which are custodial in nature; (e) habilitative services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.

14. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
15. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
16. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
17. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
18. For eyeglasses, contact lenses, hearing aids, including bone anchored hearing aids, cochlear implants, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
19. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.
20. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of 90 consecutive days.
21. As a result of an *injury* 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 w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
22. For fetal reduction *surgery*.
23. 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.
24. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or Semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any motorized vehicle or conveyance; racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).
25. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or *member* of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
26. 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.

27. For *illness* or *injury* caused by the acts or omissions of a *third party*, we will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*.
28. For the following miscellaneous items (except where required by federal or state law): in vitro fertilization, artificial insemination, biofeedback; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods provision; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-enrollee biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; private duty nursing; *rehabilitation* services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service area; sclerotherapy for varicose veins; treatment of spider veins; transportation expenses, unless specifically described in this *contract*.
29. For diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
30. For penile prosthetic *surgery* or for complications resulting from a penile implant.
31. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status. To facilitate appropriate benefit use and prevent opioid overutilization, *member*'s participation in lock-in status will be determined by review of pharmacy claims.
32. *Surrogacy arrangement*. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a *member*, and any child born as a result of a *surrogacy arrangement*. This exclusion applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the *surrogate* following childbirth);
    d. Mental Health Services related to the *surrogacy arrangement*;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
    h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement*;
    i. Any complications of the child or *surrogate* resulting from the *pregnancy*; or
    j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*.

    Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except where the child is the adoptive child of insureds possessing an active *contract* with us and/ or the child possesses an active *contract* with us at the time of birth.
33. For any medicinal and recreational use of cannabis or marijuana.
34. For any product that reasonably could be expected to be non-self-administered or for products that should be administered in a medical facility.
35. For all health care services obtained at an Urgent Care Facility that is a *non-network provider*, unless *prior authorization* is received
36. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Medical and Surgical Expense Benefits provisions.
37. Immunizations that are not *medically necessary* or medically indicated. This includes those used for travel and occupational.
38. For expenses, services, and treatments from a massage therapist to touch and manipulate the muscles and other soft tissues of the body.
39. 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.

40. For expenses, services, and treatments from a Naturopathic *specialists* for treatment of prevention, self-healing and use of natural therapies.
41. For expenses, services, and treatments related to private duty nursing in an *inpatient*, outpatient or home location.
42. Complications resulting from surgeries that arise from a non-covered procedure including those occurring prior to enrollment.
43. While confined primarily in a long term nursing facility, assisted living facility, or *custodial care*/domiciliary care facility.
44. For the treatment of infertility. **Note**: Coverage is available for diagnosis and services required to correct underlying medical causes of infertility.

PLAN ADMINISTRATION

In consideration of the payment of premiums, we will provide coverage for the *member* and any *eligible dependents*. In doing so, we may enter into agreements with providers of health care and such other individuals and entities as may be necessary to enable us to fulfill our obligations under this *contract*.

We agree to provide coverage without discrimination because of race, color, national origin, disability, sex, gender identity, sexual orientation, religion, or any other basis prohibited by law.

Commencement of Coverage

Commencing on the *contract effective date* we agree to provide the coverage stipulated in this *contract* to the *member* and his/her *dependents*, if any. Such coverage begins on the *member's effective date*, which will be the first of the month after the receipt and approval of the application by us, unless this *contract* specifies a date other than the first of the month. We accept no liability for benefits related to expenses incurred prior to your *effective date* or after your termination date, which will be on the last day of the coverage month, except or as specified in the Terms of Renewal provision.

Plan Renewal

This *contract* is guaranteed renewable. Guaranteed renewable means that this *contract* will renew each year on the anniversary date unless terminated earlier in accordance with *contract* terms. You may keep this *contract* in force by timely payment of the required premiums. We may decide not to renew as of the renewal date if: (1) we decide not to renew all *contracts* issued on this form, with the same type and level of benefits, to residents of the state where you then live; or (2) there is fraud, or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits. Rate changes are effective on a *member's* annual renewal date and will be based on each *member's* attained age, family structure, geographic region, *tobacco* usage and benefit plan at the time of renewal. We will notify the *member* in writing at least forty-five (45) days prior to the renewal date of any change in premium rates.

For *members* who have elected the electronic funds transfer option of payment, should premiums change at renewal, we will continue to draft the new monthly premium.

Term of Renewal

We guarantee the *member* the right to renew the *contract* each year, at the *member's* option. However, we may refuse to renew this *contract*, and all coverage provided under this *contract,* if one of the following circumstances has occurred:

1. Failure to timely pay premium in accordance with the terms of the *contract;*
2. We cease offering this *contract* to all *members*;
3. The *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this *contract;*
4. The *member* no longer lives in our geographic *service area;*
5. We elect to discontinue all individual health coverage in the State of Florida; and
6. We elect to discontinue offering individual health coverage.

With the exception of non-payment of premium or *loss* of eligibility, if we decide to terminate or non-renew this *contract* for any of the reasons set forth in this *contract*, we will give the *member* at least forty-five (45) days advance written notice prior to renewal. If we discontinue offering all individual coverage in Florida, we will give all *members* and the Office of Insurance Regulation 180 day's written notice prior to the *contract* non-renewal date.

Termination of This *Contract* by the *Member*

The *member* may terminate this *contract* at any time with appropriate notice of at least fourteen (14) days to us. Coverage will terminate on the date specified by the *member*, or fourteen (14) days after termination is requested, whichever is later. If the *member* requests termination in fewer than fourteen (14) days, and we can effectuate this request in a shorter period of time, then coverage will terminate on the date determined by us. No benefits will be provided as of the *effective date* of termination of this *contract* for whatever reason.

Should the *member* or any covered dependents terminate coverage because of eligibility for Medicaid, Children's Health Insurance Program (CHIP) or a Basic Health Plan or termination is due to the *member* moving from one *health plan* to another during an Annual or Special Enrollment Period, the termination *effective date* will be the day before the *effective date* of the new coverage.

Discontinuance of a Benefit Plan

We may discontinue offering a particular benefit plan to all *members* if:

1. We provide at least one hundred and eighty (180) day notice to each *member* prior to the *contract* renewal date;
2. We offer each *member* the option to purchase any other coverage offered in the individual Health Maintenance Organization (HMO) market; and
3. We act uniformly without regard to any health status-related factor of each *member*.

Discontinuance of All Coverage in the Individual Market

We may discontinue offering all coverage in Florida if:

1. We provide notice to the Office of Insurance Regulation and each *member* and enrollee 180 days prior to renewal; and
2. All health coverage issued or delivered for issuance in Florida is discontinued and coverage under such health coverage is not renewed.

Termination of this Plan by Us

Except for nonpayment of premium or termination of eligibility, we may not cancel or terminate or non-renew this *contract* without giving the *member* at least forty-five (45) days written notice. The written notice will state the reason or reasons for the cancellation, termination or non-renewal.

We may terminate this *contract* as of any premium due date if the *member* has not paid the required premium by the end of the Grace Period, as defined in the Grace Period provision. The *member* is liable to us for any unpaid premium for the time the plan was in force.

Upon termination of coverage, we will have no further liability for the payment of any *covered services* provided after the date of the *member's* termination.

Plan Termination Due to Non-Payment of Premium

If the *member* is receiving premium subsidies, the following provision applies:

- If the required monthly premium is not received by the end of the ninety (90) day Grace Period, we will terminate coverage effective at midnight on the last day of the first month of the three (3) month grace period.

If the *member* is not receiving premium subsidies, the following provision applies:

- If the required monthly premium is not received by the end of the thirty (30) day grace period, we will terminate this *contract*, without prior notification, retroactive to the last date for which premium was received, subject to the Grace Period provision. Termination will be effective as of midnight of the date that the premium was due provided we mail written notice of termination to the *member* prior to forty-five (45) days after the date the premium was due.

Termination of Coverage by Us

We may terminate coverage in a *health plan* and will also permit us to terminate coverage for any of the following reasons.

1. *Loss* of eligibility to purchase a *health plan* through us.
2. Nonpayment of premiums provided that the grace period has elapsed.
3. Coverage is rescinded.
4. We terminate or are decertified.
5. An enrollee switches to another *health plan* during an Annual Open Enrollment Period or Special Enrollment Period.

Terms of Renewal

We guarantee the *member* the right to renew the *contract* each year, at the *member's* option. However, we may refuse to renew this *contract*, and all coverage provided under this *contract*, if one of the following circumstances has occurred:

1. The *member* fails to timely pay premium in accordance with the terms of the *contract*;
2. We cease offering this *contract* to all *members;*
3. The *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this *contract*;
4. The *member* no longer lives or works in our geographic *service area;* and
5. We elect to discontinue all individual health coverage in the State of Florida.

With the exception of non-payment of premium or *loss* of eligibility, if we decide to terminate or non-renew this *contract* for any of the reasons set forth in this *contract,* we will give the *member* at least forty-five (45) days advance written notice.

Discontinuance

180-Day Notice: If we discontinue offering 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 *and all enrollees* at least 180 days prior to the date that we discontinue coverage. You will be offered an option to purchase any other coverage in the individual market we offer in your state at the time of discontinuance of this *contract*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

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

Notification Requirements

It is the responsibility of you or your former *dependent member* to notify us within 31 days of your legal divorce or your *dependent member's* marriage.

SUBROGATION AND RIGHT OF REIMBURSEMENT

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

Celtic Insurance Company retains the right to repayment of the full cost of all benefits provided by this plan on behalf of the *member* that are associated with the *third party injuries*. Celtic Insurance Company's rights of recovery apply to any recoveries made by or on behalf of the *member* from any sources, including but not limited to:

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

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

By accepting benefits under this plan, the *member* also specifically acknowledges Celtic Insurance Company's right of reimbursement. This right of reimbursement attaches when this plan has provided health care benefits for expenses incurred due to *third party* injuries and the *member* or the *member's* representative has recovered any amounts from any source. Celtic Insurance Company's right of reimbursement is cumulative with and not exclusive of Celtic Insurance Company's subrogation right and Celtic Insurance Company may choose to exercise either or both rights of recovery.

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

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

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

We have a right to be reimbursed in full regardless of whether or not the *member* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

We will not pay attorney fees or costs associated with the *member's* claim or lawsuit. In the event you or your representative fail to cooperate with Celtic Insurance Company, you shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by Celtic Insurance Company in obtaining repayment.

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

COORDINATION OF BENEFITS

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

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

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

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

"Plan" as used in this section is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

1. Group and non-group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group and individual HMO insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.
2. Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
3. *Hospital*, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid.

The plan does not include:

1. Blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
2. Plan does not include coverage, which by law, provides benefits that are in excess of those of any private insurance plan or other nongovernment plan.

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

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

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

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 2-9 that applies will determine which plan will be primary:

1. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. A plan may consider benefits paid or provided by another plan in determining its benefits only when it is secondary to that *other plan*.
2. If the *other plan* does not contain a coordination of benefits provision that is consistent with this provision then it is always primary. There are two exceptions:
    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the *contract* holder; and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987, which provides excess major medical benefits intended to supplement any basic benefits on a *covered person* may continue to be excess to such basic benefits.
    3. If the person receiving benefits is our *member* and is only covered as an eligible dependent under the *other plan*, this *contract* will be primary.
4. However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a dependent of an active employee (a Medicare beneficiary also has another group plan), then the order of benefit determination is:
    a. First, benefits of a plan covering a person as an employee, *member*, or subscriber.
    b. Second, benefits of a plan of an active worker covering a person as a dependent;
    c. Third, Medicare benefits.
5. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
    a. If both parents have the same birthday, the plan which covered the parent longer will be primary.
    b. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the *other plan* does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the *other plan* will determine which plan is primary.
6. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
    a. The plan of the parent who has custody will be primary;
    b. If the parent with custody has remarried, and the child is also covered as a child under the stepparent's plan, the plan of the parent with custody will pay first, the stepparent's plan will pay second, and the plan of the parent without custody will pay third.
7. If a child's coverage is based on a court decree, and the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child and if the entity obliged to pay or provide the benefits of the *contract* or plan of that parent has actual knowledge of those terms, the benefits of that *contract* or plan are determined first. The parent with responsibility that has no health care coverage for the dependent child's health care expenses, but that parent's *spouse* does, that parent's *spouse's* plan is the primary plan.

8. If the person receiving services is covered under one plan as an active employee or *member* (i.e., not laid-off or retired), or as the *spouse* or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the *spouse* or child of such a laid-off or retired employee, the plan that covers such person as an active employee or *spouse* or child of an active employee will be primary. If the *other plan* does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
9. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Ambetter's maximum allowable benefit for each *covered service*. Also, the amount Ambetter pays will not be more than the amount Ambetter would pay if Ambetter were primary. As each claim is submitted, Ambetter will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

In the event of multiple forms of coverage, Ambetter reserves the right to reduce or refuse to pay benefits otherwise payable on the account of existing of similar benefits provided under insurances policies issued by the same or another insurer, in accordance with state and federal laws. As a condition of coordinating benefits, the insurers together pay 100 percent of the total reasonable expenses actually incurred of the type of expense within the benefits described in the policies and presented to the insurer for payment.

Effect of Medicare

Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status, and will be adjudicated by us as set forth in this section. When Medicare, Part A and Part B or Part C is primary, Medicare's allowable amount is the highest allowable expense.

Right to Receive and Release Needed Information

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

CLAIMS

Notice of Claim
When a *non-network provider* renders services, notice of a claim for benefits must be given to us. The notice must be in writing, should include the name of the insured and *member* identification number, and any claim will be based on that written notice. The notice must be received by us within 20 days after the date of the *injury* or the first treatment date for the sickness on which the claim is based and may be given to us or your agent. If this required notice is not given in time, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit the notice within the 20 day period and that notice was given as soon as possible, the claim will not be reduced or invalidated.

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

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

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

If you have paid for services we agreed to cover, you can request reimbursement for the amount you paid. We can adjust your *deductible, copayment amount* 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 will also need to submit a copy of the *member* reimbursement claim form posted at Ambetter.SunshineHealth.com under "*Member* Resources". Send all the documentation to us at the following address:

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

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

1. Sign, date and deliver to us *authorizations* to obtain any medical or other information, records or documents we deem relevant from any person or entity.
2. Obtain and furnish to us, or our representatives, any medical or other information, records or documents we deem relevant.

3. Answer, under oath or otherwise, any questions we deem relevant, which we or our representatives may ask.
4. Furnish any other information, aid or assistance that we may require, including without limitation, assistance in communicating with any person or entity, including requesting any person or entity to promptly provide to us, or our representative, any information, records or documents requested by us.

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

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

Time for Payment of Claims

Benefits will be paid as soon as we receive proper *proof of loss*. We will reimburse all claims or any portion of any claim within 45 days after receipt of the claim. If a claim or a portion of a claim is contested, you or your assignees shall be notified, in writing, that the claim is contested or denied, within 45 days after we receive the claim from you. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim. Upon receipt of the additional information requested you or your assignees, we shall pay or deny the contested claim or portion of the contested claim, within 60 days.

"Clean claims" means a claim submitted by you or a provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If we have not received the information we need to process a claim, we will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information. In those cases, we cannot complete the processing of the claim until the additional information requested has been received. We will make our request for additional information within 30 days of our initial receipt of the claim and will complete our processing of the claim within 15 days after our receipt of all requested information.

We shall pay or deny any claim no later than 120 days after receiving the claim. Payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery. All overdue payments shall bear simple interest at the rate of 10 percent per year.

Upon your written notification, we will investigate any claim of improper billing by a *physician*, *hospital*, or other health care provider. We will determine if you were properly billed for only those procedures and services that the *covered person* actually received. If we determine that you have been improperly billed, we shall notify you and the provider of our findings and shall reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such notification by us, we shall pay to you 20 percent of the amount of the reduction up to $500.

Payment of Claims

We may elect to pay, in our discretion, all or any part of the benefits provided by this *contract* for *hospital*, surgical, nursing, or medical services, directly to the *hospital* or other party providing such services to you. By reserving the right to pay, in our discretion, all or any part of the benefits provided for in this *contract* directly to a *hospital* or other person providing surgical, nursing, or medical services to you, we are not granting any *hospital* or other person rendering surgical, nursing, or medical services any right to demand

direct payment or any right to enforce any provision of this *contract*; nor are we waiving the Non-Assignment provision of this *contract* set forth below.

Foreign Claims Incurred for Emergency Care

Medical *emergency* care is a *covered service* 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.SunshineHealth.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.

***Appeal* Procedures for Claims**

Refer to the Internal *Grievance*, Internal *Appeals* and External *Appeals* Procedures provisions of this *contract* for information on your right to *appeal* the adjudication of a claim.

Non-Assignment

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

Notwithstanding the foregoing, you may specifically authorize, in writing, the payment of benefits that we have determined to be due and payable directly to any *hospital, provider*, or other person who provided you with any *covered service* and we will honor this specific direction and make such payment directly to the designated provider of the *covered service*.

No *Third Party* Beneficiaries

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

Medicaid Reimbursement

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

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

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

Custodial Parent

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

Upon request by the custodial parent, we will:

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

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

Physical Examination

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

Legal Actions

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

Prior to initiating any action at law, you are encouraged to first complete all the steps in the *complaint/grievance/appeal* procedures made available to resolve disputes in Florida under the *contract*. After completing that *complaint/grievance/appeal* procedures process, if you want to bring legal action against us on that dispute, you must do so within one year of the date we notified you of the final decision on your *complaint/grievance/appeal*.

GRIEVANCE AND COMPLAINT PROCEDURES

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

Complaints

Complaints are the lowest form of a problem. It gives us the opportunity to resolve your problem without it becoming a formal *grievance*. Examples of a *complaint* include but not limited to, when you are unhappy with:

- Care received from a provider
- Services received from a provider
- How long it takes to get an appointment
- How a *member* was treated
- Services that is not included as an Ambetter from Sunshine Health benefit
- How a bill was paid
- How you were treated by Ambetter from Sunshine Health staff

If you have a *complaint,* you may file your *complaint* in writing or by speaking with our *Member* Services department at 1-877-687-1169 or Relay FL 1-800-955-8770. *Complaints* are generally resolved within 72 hours following the receipt of the *complaint*. If you are not satisfied with the outcome of the *complaint*, you can request that your *compliant* be moved to a formal *grievance*.

Grievances

A *grievance*, as referred to in this section, is a written *complaint* about anything other than an *adverse determination*. *Grievances* may refer to any dissatisfaction about:

a) Us, as the insurer; e.g., customer service *grievance*s - "the person to whom I spoke on the phone was rude to me";
b) *Providers* with whom we have a direct or indirect *contract*;
    i) Lack of availability and/or accessibility of *network providers* not tied to an unresolved benefit denial; and
    ii) Quality of care/quality of service issues;
c) Expressions of dissatisfaction regarding quality of care/quality of service;

Filing a *Grievance*

You have 365 days from the date the issue occurred to file a *grievance* with us. You or your *authorized representative* may file a *grievance* by calling *Member* Services at 1-877-687-1169 or Relay FL 1-800-955-8770. At the time of your initial *grievance,* you will be informed that you have the right to file a written *grievance*. At your request, we will provide assistance to you in preparing the written *grievance*.

Written *grievances* may be sent to:

Ambetter from Sunshine Health
***Grievance* and *Appeal* Coordinator**
P.O. Box 459089
Fort Lauderdale, FL 33345-9089
Phone: 1-877-687-1169 or Relay FL 1-800-955-8770
Fax: 1-866-534-5972
Email: Sunshine *Appeals*@centene.com

In your written *grievance*, please include:

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

You can file an *urgent grievance* for a situation that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. Decisions regarding expedited *grievances* will be made as expeditiously as the *member's* health condition requires, but no later than 72 hours.

Process and Resolution Timeframes

We will acknowledge your *grievance* by sending you a letter within five (5) business days of receipt of your *grievance*.

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

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

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

Appeal

An appeal is a *grievance* involving a request to review, overturn, or otherwise modify an *adverse determination*. An *adverse determination* is coverage determination by us that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and coverage for the requested service is therefore denied, reduced, or terminated. You can *appeal* these decisions. You can also designate a representative –such as a family *member*, friend, *physician*, or attorney- to *appeal* these decisions on your behalf.

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

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

Ambetter from Sunshine Health
***Grievance* and *Appeal* Coordinator**
P.O. Box 459089
Fort Lauderdale, FL 33345-9089
Phone: 1-877-687-1169 or Relay FL 1-800-955-8770
Fax: 1-866-534-5972
Email: Sunshine *Appeals*@centene.com

You can also file an *appeal* via phone by contacting us at 1-877-687-1169 or Relay FL 1-800-955-8770. Verbal request must be followed up in writing within 10 calendar days.

Call us at 1-877-687-1169 or Relay FL 1-800-955-8770 if you have any questions regarding the process or how to file an *appeal*. We will provide an interpreter or TTY services for you if you need them.

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

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

We may extend our deadline by no more than 14 days if we need additional information to reach a decision. We will inform you of the request's status if such an extension is necessary. If we do not receive the required information within the extended timeframe, we will make a determination based on the information we have. If no extension is needed, we will make the decision within 30 calendar days of receipt of your pre-service *appeal* or within 60 calendar days of receipt of your post-service *appeal*. We will notify you in writing within two (2) business days of the decision.

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

Expedited Appeal
An *expedited appeal* provides for evaluation by appropriate clinical peer or peers (who were not involved in the initial *adverse determination)* within 24 hours.

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

You may request an *expedited appeal* at any time. You may start the *appeal* process by phone or in writing. You may call 1-877-687-1169 or Relay FL 1-800-955-8770 to initiate an *expedited appeal* request.

We will make a decision about the request within 72 hours. We will notify you, your *provider*, and your *authorized representative*, if applicable, of the result. We will notify you in writing within two (2) business days of the decision.

External Review

Our *member*s are offered two levels of *appeal* for *adverse determinations* related to a service that requires medical review. An external review decision is binding on us. An external review decision is binding on the claimant except to the extent the claimant has other remedies available under applicable federal or state law. We will pay for the costs of the external review performed by an independent reviewer.

Applicability/Eligibility

The external review procedures apply to any *hospital* or medical *contract* or certificate; excluding accident only or disability income only insurance.

External review is available for *appeals* that involve:

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

After exhausting our internal review process, you can make a written request to the *Appeal*s & *Grievance* Department for an external review after the date of receipt of our internal response. We will send your request to an Independent Review Organization (IRO). You must contact the IRO or us within 120 calendar days (4 months) of the date of your *appeal* resolution letter. If you do not file your *appeal* for an external independent review within 120 calendar days, it cannot be reviewed. If you are not sure whether your *appeal* is eligible, or if you want more information, please contact us.

To initiate an external *appeal*:

1. The internal *appeal* process must be exhausted before you may request an external review unless you file a request for an expedited external review at the same time as an internal *expedited appeal* or we either provide a waiver of this requirement or fail to follow the *appeal* process.
2. We must allow you to make a request for an expedited external review with us at the time you receive:
    a. An *adverse benefit determination* if the determination involves a medical condition of the claimant for which the timeframe for completion of an internal *expedited appeal* would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an internal *expedited appeal*.

b. A final internal *adverse benefit determination*, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal *adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service for which you received *emergency services*, but has not been discharged from a facility.

3. You may request an expedited external review at the same time the internal *expedited appeal* is requested and an IRO will determine if the internal *expedited appeal* needs to be completed before proceeding with the expedited external review.

External Review Process

1. We have five (5) business days (immediately for expedited external review) following receipt of the request to conduct a preliminary review of the request to determine whether:
   a. The individual was a *covered person* at the time the item or service was requested;
   b. The service is a *covered service* under your health plan but for the plan's *adverse benefit determination* with regard to *medical necessity experimental or investigational,* medical judgment, or *rescission*;
   c. You have exhausted the internal process; and
   d. You have provided all of the information required to process an external review.
2. Within one (1) business day (immediately for expedited external review) after completion of the preliminary review, we will notify you in writing as to whether the request is complete but not eligible for external review and the reasons for its ineligibility or if the request is not complete, the additional information needed to make the request complete. We will include notification of your right to submit written testimony to be included in the materials sent to the IRO.
3. We must allow you to perfect the request for external review within the four(4)-month filing period or within the 48-hour period following the receipt of notification.
4. We will assign an IRO on a rotating basis from our list of contracted IROs.
5. Within five (5) business days after the date of assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO. **Note:** For expedited external review, after assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method.
6. If we fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the *adverse benefit determination*.
7. Within 10 business days, the assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that you may submit in writing additional information to the IRO to consider.
8. Upon receipt of any information submitted by you, the IRO must forward the information to us within one (1) business day.
9. Upon receipt of the information, we may reconsider our determination. If we reverse our *adverse benefit determination*, we must provide written notice of the decision to you and the IRO within one (1) business day after making such decision. The external review would be considered terminated.
10. Within 45 days (72 hours for expedited external review) after the date of receipt of the request for an external review by the health plan, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to you and to us. If the notice for an expedited external review is not in writing, the IRO must provide written confirmation within 48 hours after the date of providing the notice.
11. Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, we will approve the *covered service* that was the subject of the *adverse benefit determination*.

After you receive a decision from us concerning your benefits and feel further action is needed, you have the right to file a *complaint* with the Department of Financial Services, Division of Consumer Services.

You may request assistance of the Department of Financial Services, Division of Consumer Services by telephone at 1-877-MY-FL-CFO (1-877-693-5236), or if calling from outside of Florida (1-850-413-3089), by email at ConsumerServices@myfloridacfo.com, or online at: http://www.myfloridacfo.com/Division/Consumers/

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

Written Grievance/Appeal Response

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

The written decision must include:

1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *grievance* or *appeal*;
3. The signature of one (1) voting *member* of the panel, if applicable;
4. A written description of position titles of panel *members* involved in making the decision.
5. If upheld or partially upheld, it is also necessary to include:
    a. A clear explanation of the decision;
    b. Reference to the specific plan provision on which the determination is based;
    c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
    d. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse determination*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse determination* and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;
    e. If the *adverse benefit determination* is based on a medical necessity or *experimental* treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
    f. Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse benefit determination*;
    g. The date of service;
    h. The health care *provider's* name;
    i. The claim amount;
    j. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis or procedure codes are available upon request;
    k. The health plan's denial code with corresponding meaning;
    l. A description of any standard used, if any, in denying the claim;
    m. A description of the external review procedures, if applicable;

n. The right to bring a civil action under state or federal law;
o. A copy of the form that authorizes the health plan to disclose protected health information, if applicable;
p. That assistance is available by contacting the specific state's consumer assistance department, if applicable; and
q. A culturally linguistic statement based upon your county or state of *residence* that provides for oral translation of the *adverse benefit determination*, if applicable.

***Appeals* and *Grievances* filing and key communication timelines**

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard *Grievance*	365 Calendar Days	5 Business Days	30 Calendar Days	14 Calendar Days
Urgent Grievance	365 Calendar Days	N/A	72 hours	N/A
Standard Pre-Service *Appeal*	180 Calendar Days	5 Business Days	30 Calendar Days	14 Calendar Days
Expedited Pre-Service *Appeal*	180 Calendar Days	N/A	72 hours	N/A
Standard Post-Service *Appeal*	180 Calendar Days	5 Business Days	60 Calendar Days	14 Calendar Days
External Review	4 Months	6 Business Days	45 Calendar Days	N/A
Expedited External Review	4 Months	Immediately	72 hours	N/A

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

GENERAL PROVISIONS

Entire Contract
This *contract*, with the application and any rider-amendments is the entire *contract* between you and us. No party or agent of a party may:

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

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

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

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

We will provide the *member* forty-five (45) days advance written notice before coverage is rescinded.

Time Limit on Certain Defenses
Relative to a misstatement in the application, after 2 years from the issue date, only fraudulent misstatements in the application may be used to void the *contract* or deny any claim for *loss* incurred or disability starting after the 2-year period.

Repayment for Fraud, Misrepresentation or False Information
During the first two years a *member* is covered under the *contract*, if a *member* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *contract* or in filing a claim for *contract* benefits, we have the right to demand that *member* pay back to us all benefits that we provided or paid during the time the *member* was covered under the *contract*. We will return any premium paid during the time period for which the *member* returned benefit payments.

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

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

Performance Outcomes and Financial Data
You may obtain information regarding performance outcomes and financial data for Celtic Insurance Company published by the State of Florida Agency for Health Care Administration by accessing Ambetter from Sunshine Health's website: Ambetter.SunshineHealth.com. This website includes the link to FloridaHealthStat where this information is published.

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://ambettersunshinehealth.com/privacy-practices.html or call *Member* Services at 1-877-687-1169 (Relay FL 1-800-955-8770).

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

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

Statement of Non-Discrimination

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

Ambetter from Sunshine 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 Sunshine Health at 1-877-687-1169 (Relay FL 1-800-955-8770).

If you believe that Ambetter from Sunshine 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 Unit Sunshine Health, P.O. Box 459089 Fort Lauderdale, FL 33345-9089, 1-877-687-1169 (Relay Florida 1-800-955-8770), Fax, 1-866-534-5972. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from Sunshine 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 (TYY).

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

Declaración de no discriminación

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

Ambetter de Sunshine 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 Sunshine Health a 1-877-687-1169 (Relay FL 1-800-955-8770).

Si considera que Ambetter de Sunshine 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 Unit Sunshine Health, P.O. Box 459089 Fort Lauderdale, FL 33345-9089, 1-877-687-1169 (Relay Florida 1-800-955-8770), Fax, 1-866-534-5972. Usted puede presentar una queja por correo, fax, o correo electrónico. Si necesita ayuda para presentar una queja, Ambetter de Sunshine 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 (TYY).

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

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Sunshine Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-687-1169 (Relay Florida 1-800-955-8770).
French Creole:	Si oumenm, oubyen yon moun w ap ede, gen kesyon nou ta renmen poze sou Ambetter from Sunshine Health, ou gen tout dwa pou w jwenn èd ak enfòmasyon nan lang manman w san sa pa koute w anyen. Pou w pale avèk yon entèprèt, sonnen nimewo 1-877-687-1169 (Relay Florida 1-800-955-8770).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Sunshine 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 1-877-687-1169 (Relay Florida 1-800-955-8770).
Portuguese:	Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from Sunshine Health, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-687-1169 (Relay Florida 1-800-955-8770).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Sunshine 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 1-877-687-1169 (Relay Florida 1-800-955-8770)。
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Sunshine Health, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-877-687-1169 (Relay Florida 1-800-955-8770).
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Sunshine Health, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-687-1169 (Relay Florida 1-800-955-8770).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Sunshine Health вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-877-687-1169 (Relay Florida 1-800-955-8770).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Sunshine Health ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-687-1169 (Relay Florida 1-800-955-8770).
Italian:	Se lei, o una persona che lei sta aiutando, avesse domande su Ambetter from Sunshine Health, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l'1-877-687-1169 (Relay Florida 1-800-955-8770).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Sunshine 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 1-877-687-1169 (Relay Florida 1-800-955-8770) an.
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Sunshine Health에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-687-1169 (Relay Florida 1-800-955-8770) 로 전화하십시오.
Polish:	Jeżeli ty lub osoba, której pomagasz, macie pytania na temat planów za pośrednictwem Ambetter from Sunshine Health, macie prawo poprosić o bezpłatną pomoc i informacje w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer 1-877-687-1169 (Relay Florida 1-800-955-8770).
Gujarati:	જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter from Sunshine Health વિશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-877-687-1169 (Relay Florida 1-800-955-8770) ઉપર કૉલ કરો.
Thai:	หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีคำถามเกี่ยวกับ Ambetter from Sunshine Health ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข 1-877-687-1169 (Relay Florida 1-800-955-8770).