ambetter. of Illinois | Insured by Celtic Insurance Company

2023 Evidence of Coverage

AmbetterofIllinois.com

Member Services Department: 1-855-745-5507 (TTY 1-844-517-3431)

Log on to: AmbetterofIllinois.com

Insured by Celtic Insurance Company

Ambetter of Illinois insured by Celtic Insurance Company
EVIDENCE OF COVERAGE
Home Office: 200 East Randolph St., Suite 3600, Chicago, IL 60601

Individual *Member* HMO *Contract*

In this *contract,* the terms "you" or "your" will refer to the *member* or any *dependent members* enrolled in this *contract*. The terms "we," "our," or "us" will refer to Ambetter of Illinois insured by Celtic Insurance Company.

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

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

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

At least 31 day notice of any plan to take an action or make a change permitted by this clause will be delivered to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under this *contract* or a change in a *member's* health. While this *contract* is in force, we will not restrict coverage already in force. If we discontinue offering and decide not to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 90 days prior to the date that we discontinue coverage.

This *contract* contains *prior authorization* requirements. You are 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 the *Schedule of Benefits* and the *Prior Authorization* section.

TEN DAY RIGHT TO RETURN CONTRACT

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

Ambetter of Illinois insured by Celtic Insurance Company

Kevin J. Counihan
President – Celtic Insurance Company

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INTRODUCTION

Welcome to Ambetter of Illinois insured by Celtic Insurance Company. We have prepared this *contract* to help explain your coverage. Please refer to this *contract* whenever you require medical services. It describes:

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

This *contract*, the *Schedule of Benefits*, and application shall constitute the entire *contract* under which *covered services* and supplies are provided or paid for by us.

Because many of the provisions are interrelated, you should read this entire *contract* to gain a full understanding of your coverage. Many words used in this *contract* have special meanings when used in a health care 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 also see references for Celtic Insurance Company and Ambetter of Illinois. Both references are correct, as Ambetter of Illinois operates under its legal entity, Celtic Insurance Company.

How to Contact Us
Ambetter of Illinois
200 East Randolph St.
Chicago, IL 60601

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. CST, Monday through Friday
Member Services **1-855-745-5507**
TTY line **1-844-517-3431**
Fax **1-855-519-5699**
Emergency **911**
24/7 Nurse Advice Line **1-855-745-5507**

Interpreter Services
Ambetter of Illinois insured by Celtic Insurance Company has a free service to help our *members* who speak languages other than English. These services ensure you and your *physician* can talk about your medical or *behavioral health* concerns in a way that is most comfortable for you.

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

To arrange for interpretation services, please call Member Services at 1-855-745-5507 or for hard of hearing (TTY 1-844-517-3431).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

If you have difficulty locating a *primary care physician (PCP)*, *specialist*, *hospital* or other contracted provider please contact us so we can assist you with accessing or locating a provider who is contracted with us. *Physicians* within our *network* may be affiliated with different *hospitals*. Our online directory can provide you with information for the *hospitals* that are contracted with us. The online directory also lists affiliations that your provider may have with non-contracted *hospitals*. Your Ambetter coverage requires you to use contracted providers with limited exceptions. You can access the online directory at www.AmbetterofIllinois.com.

You have the right to:

1. Participate with your *physician* 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*, and other facilities, and your rights and responsibilities.
7. Candidly discuss with your *physician* and *medical practitioners* appropriate and *medically necessary* care for your condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *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 this *contract*, 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 *physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
8. Make recommendations regarding *member*'s rights, responsibilities and policies.
9. Voice *complaints* or *appeals* about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
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 the following:
    a. Any changes in clinical review criteria
    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*.
13. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
14. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, ethnicity, race, religion, gender, sex, sexual orientation, national origin, physical or mental disability, or expected health or genetic status.
15. Access *medically necessary* urgent and *emergency services* 24 hours a day and seven days a week.
16. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.
17. Refuse treatment to the extent the law allows without jeopardizing future treatment, and be informed by your provider(s) of the medical consequence. You are responsible for your actions if treatment is refused or if the *PCP's* instructions are not followed. You should discuss all concerns about treatment with your *PCP*. Your *PCP* can discuss different treatment plans with you, if there is more than one option that may help you. You will make the final decision.
18. 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.
19. Know the name and job title of people giving you care. You also have the right to know which *physician* is your *PCP*.
20. An interpreter when you do not speak or understand the language of the area.
21. A second opinion by a *network provider*, if you want more information about your treatment or would like to explore additional treatment options.
22. 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 incapacitated. You have the right to have your wishes known by completing advance directive forms. Advance directive 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
    c. "Do Not Resuscitate" Orders. *Members* also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this entire *contract.*
2. Treat all 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. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your *physician* until you understand the care you are receiving.
4. Review and understand the information you receive about us. You need to know the proper use of *covered services*.
5. Show your *member* identification card and keep scheduled appointments with your *physician*, and call the *physician*'s office during office hours whenever possible if you have a delay or cancellation.
6. Know the name of your assigned *PCP.* You should establish a relationship with your *physician*. You may change your *PCP* verbally or in writing by contacting our Member Services Department.
7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
8. Follow the treatment plans and instructions for care that you have agreed on with your health care professionals and *physician*.
9. Tell your health care professional and *physician* if you do not understand your treatment plan or what is expected of you. You should work with your *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.
10. Follow all health benefit plan guidelines, provisions, policies and procedures.

11. Use any *emergency* room only when you think you have a medical *emergency*. For all other care, you should call your *PCP*.
12. 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 the entity with which you enrolled.
13. Pay your monthly premium on time and pay all *deductible amounts, copayment amounts*, or *coinsurance amounts* at the time of service.
14. Notify us or the entity you enrolled with of any enrollment related changes that would affect your *contract* within 60 days from the date of the event. Enrollment related changes include the following: birth of a child, or adoption, marriage, divorce, adding/removing a *dependent member*, *spouse*/domestic partner becomes eligible under a different insurer, enrollment changes, 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 AmbetterofIllinois.com. We have *network physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide you with your health care services. You may find any of our *network providers* by completing the "Find a Provider" function on our website and selecting the Ambetter of Illinois insured by Celtic Insurance Company *network*. There you will have the ability to narrow your search by provider specialty, zip code, gender, languages spoken, and whether or not they are currently accepting new patients. Your search will produce a list of providers based on your search criteria and will give you other information such as name, address, phone number, office hours, specialty and board certifications.

At any time, you can request a copy of the Provider Directory at no charge by calling Member Services at 1-855-745-5507 (TTY 1-844-517-3431). In order to obtain benefits, you must designate a *network primary care physician (PCP)* for each *member.* We can help you pick 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 1-855-745-5507 (TTY 1-844-517-3431). We will help you make the appointment.

Member Identification Card
We will mail a *member* identification card after we receive your completed enrollment materials and you have paid your initial premium payment. This card is proof that you are enrolled in an Ambetter of Illinois insured by Celtic Insurance Company 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 1-855-745-5507 (TTY 1-844-517-3431), twenty-four hours per day, seven days a week. We will send you another card. A temporary identification card can be downloaded from www.AmbetterofIllinois.com.

Website
Our website can answer many of your frequently asked questions. Our website has resources and features that make it easy to get quality care. Our website can be accessed at AmbetterofIllinois.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. Selecting a *PCP*.
5. *Deductible* and *co-payment* accumulators.
6. Our *formulary* or preferred drug list.
7. Member Rights and Responsibilities.
8. Notice of Privacy.
9. Current events and news.

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

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 *physicians* when they become part of the provider *network*.
2. Providing programs and educational items about general health care 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 the Member Services Department.

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

Protection from Balance Billing

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

1. *Emergency services* provided to a *member*, regardless of plan participation; or
2. Non-emergency health care services provided to a *member* at 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 non-*network provider* pursuant to the federal No Surprises Act.

Please review the **Access to Care** and **Medical Service Benefits** 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*:

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.

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*.

Adverse benefit determination means a decision by us which results in:

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

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

Regarding the independent review procedures, this includes the denial of a request for a referral for non-*network* services when the *member* requests health care services from a provider that does not participate in the provider *network* because the clinical expertise of the provider may be *medically necessary* for treatment of the *member's* medical condition and that expertise is not available in the provider *network*.

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

Affordable Care Act (ACA) means the comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and *Affordable Care Act* (*ACA*) was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "*Affordable Care Act*" is used to refer to the final, amended version of the law. This is often times referred to as Health Care Reform.

Allowed amount (also see ***Eligible Expense***) means the maximum amount we will pay a provider for a *covered service*. When a *covered service* is received from a *network provider*, the *allowed amount* is the amount the provider agreed to accept from us as payment for that particular service. In all cases, the *allowed amount* will be subject to *cost sharing* (e.g., *deductible*, *coinsurance* and *copayment*) per the *member's* benefits. This amount excludes any payments made to the provider by us as a result of federal or state arbitration.

Please note, if you receive non-emergent 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 non-*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 www.ambetterofillinois.com/health-plans/our-benefits/ambetter-telehealth.html.

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

Applied behavior analysis 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.

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

Authorization or ***Authorized*** means our decision to approve the *medical necessity* or the appropriateness of care for a *member* by the *member's PCP* or provider.

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 *appeal* 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.

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.

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 providers* may not balance bill you for *covered service expenses* beyond your applicable *cost sharing* amounts. If you are ever *balance billed* contact Member Services immediately at the number listed on the back of your *member* identification card.

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

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

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

Breast tomosynthesis means a radiologic procedure that involves the acquisition of projection images over the stationary breast, to produce cross-sectional digital three-dimensional images of the breast.

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

Chiropractic care 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*.

Civil Union means to allow same sex and different sex couples to enter into a *civil union* with all the obligations, protections, and legal rights that Illinois provides to married heterosexual couples.

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

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

Complications of pregnancy means:

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

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

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

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

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

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

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

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

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

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

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

Dental services means *surgery* or services, including ancillary 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, civil union* 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*.

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 cancer clinical trial means a cancer clinical trial that meets all of the following criteria:

1. A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
2. The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
3. The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
4. The trial does one of the following:
    a. Tests how to administer a health care service, item, or drug for the treatment of cancer;
    b. Tests responses to a health care service, item, or drug for the treatment of cancer;
    c. Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
    d. Studies new uses of a health care service, item, or drug for the treatment of cancer.
5. The trial must meet the following criteria:
    a. The effectiveness of the treatment has not been determined relative to established therapies;
    b. The trial is under clinical investigation as part of an approved cancer research trial in Phase II, Phase III, or Phase IV of investigation;
    c. The trial is approved by the Food and Drug Administration; or
    d. The trial is approved and funded by one of the following entities:
        i. National Institutes of Health, the Centers for Disease Control and Prevention, the Agency of Healthcare Research and Quality;
        ii. The United States Department of Defense;
        iii. The United States Department of Veterans' Affairs;
        iv. The United States Department of Energy in the form of an *investigational* new drug application, or a cooperative group or center of any entity described.
    e. The patient's *primary care physician (PCP)*, if any, is involved in the coordination of care

Eligible child means the child of a *member*, 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 stepchild;
4. A child placed with you for adoption;
5. A child for whom legal guardianship has been awarded to you or your *spouse*. It is your responsibility to notify the entity with which you enrolled (either the Health Insurance Marketplace or us) if your child

ceases to be an *eligible child*. You must reimburse us for any benefits that we provide or pay for a child at a time when the child did not qualify as an *eligible child*;
6. A child who is in your custody, pursuant to an interim court order of adoption; or
7. A foster child placed in your custody, regardless of whether the child is residing with the *member*.

Coverage is extended for unmarried *eligible child* under the age of 30 if the *dependent member*:
1. is an Illinois resident;
2. served as a *member* of the active or reserve components of any of the branches of the Armed Forces of the United States; and
3. has received a release or discharge other than a dishonorable discharge.

To be eligible for coverage, the unmarried *eligible child* shall submit to Ambetter a form approved by the Illinois Department of Veterans' Affairs stating the date on which the unmarried *eligible child* was released from service.

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

Eligible expense means a *covered service* as determined below.
1. For *network providers:* When a *covered service* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.
2. For *non-network providers,* unless otherwise required by federal or Illinois law, the *eligible expense* is as follows:
    a. When a covered *emergency service* is received from a *non-network provider* at a non-*network* facility or a covered air ambulance service is received from a *non-network provider*, 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* is reimbursement as determined by us and as required by applicable law. *Member cost share* will be calculated from the recognized amount based upon applicable law. You 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.
    b. When the *emergency,* radiology, anesthesiology, pathology, or neonatology services are received from a *non-network provider* 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* is reimbursement as determined by us and as required by applicable 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. Except as provided under (2)(b) above, 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* is reimbursement as determined by us and as required by applicable law. Unless you receive and sign the necessary written notice and consent document under federal law before the services are provided, you 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. *Member cost share* will be calculated from the recognized amount based upon applicable law. If you are *balance billed* in these

situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.

d. When a *covered service* is received from a *non-network provider* because the service or supply is not available from any *network provider* in your *service area* and is not the result of an *emergency*, the *eligible expense* is the negotiated fee, if any, that the provider has agreed to accept as payment in full (you will not be billed for the difference between the negotiated fee and the provider's charge). If there is no negotiated fee agreed to by the provider with us, the *eligible expense* is the greatest of the following: (1) the amount that would be paid under Medicare, (2) the amount for the *covered service* calculated using the same method we generally use to determine payments for *non-network providers*; or (3) the contracted amount paid to *network providers* within the same geographic region 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. You should not be *balance billed* by the provider, if you are, please contact Member Services.

e. For all other *covered services* received from a *non-network provider* for which any needed *authorization* is received from us, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full (you will not be billed for the difference between the negotiated fee and the provider's charge). If there is no negotiated fee agreed to by the provider with us, the *eligible expense* is the greatest of the following: (i) the amount that would be paid under Medicare; (ii) the amount for the *covered service* calculated using the same method we generally use to determine payments for *non-network providers*; or (iii) 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 Services **(includes *Emergency Medical, Behavioral Health,* and *Substance Use Disorder Services*)** means covered *inpatient* and *outpatient services* that are (1) furnished by a provider qualified to furnish these services and (2) needed to evaluate or stabilize an *emergency* medical/*behavioral health* condition. An *emergency* medical/*behavioral health* condition means a medical, mental health, or *substance use disorder*-related condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

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

If you are experiencing an *emergency*, call 9-1-1 or go to the nearest *hospital.*

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

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 *membe*r to regain maximum function;
2. In the opinion of a *physician* with knowledge of the *member's* medical condition, the claimant is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*; and
3. A *physician* with knowledge of the *member's* medical condition determines that the *grievance* shall be treated as an *expedited appeal*.

Experimental or ***investigational*** 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;* or
    d. It has FDA approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the FDA or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*
4. *Experimental* or *investigational* 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*, or *rehabilitation facility* by the state in which it operates;
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *physician* and the direct supervision of a registered nurse;
3. Maintains a daily record on each patient;
4. Has an effective *utilization review* plan;
5. Provides each patient with a planned program of observation prescribed by a *physician;* and
6. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing standards of medical practice for that condition.

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

Formulary means our list of covered drugs available on our website at AmbetterofIllinois.com or by calling our Member Services department.

1. Generic drug is a drug that is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the FDA as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug. Generic drugs will be dispensed whenever available.

2. Brand drug is a *prescription drug* that has been patented and is only available through one manufacturer. Preferred brand drugs will be dispensed if there is not a generic. Brand drugs are also often preferred because they are safer or more successful in producing a desired or intended result.
3. Non-Preferred drug is a *prescription drug* covered under a higher *cost share*. This tier of drug contains both *formulary* brand name and generic drugs. These drugs require higher *copay* because other alternatives may be available in the lower tiers or there may be other generic equivalents available.
4. Specialty drugs are typically high-cost drugs, including but not limited to the oral, topical, inhaled, inserted or implanted, and injected routes of administration. Included characteristics of Specialty drugs are drugs that are used to treat and diagnose rare or complex diseases, require close clinical monitoring and management, frequently require special handling, and may have limited access or distribution. Specialty drugs are often also drugs that require special handling, or special or enhanced patient administration and oversight.

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

If no credible scientific evidence is available, then standards that are based on *physician* specialty society recommendations or professional standards of care may be considered. We reserve the right to consult medical professionals in determining whether a 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 any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing in any form to the insurer by, or on behalf of, a *member* including any of the following:
1. Provision of services;

2. Determination of a diagnosis or level of service required for evidence-based treatment of *autism spectrum disorders*; and
3. Claims practices.

Grievance Committee means individuals who have been appointed by us to respond to *grievances* that have been filed on *appeal* from our simplified *complaint* process established pursuant to the regulation. At least 50 percent of the individuals on this committee will be members who are consumers.

Habilitation or ***habilitation services*** means health care services that help a patient keep, learn, or improve skills and functioning for daily living. These services may be performed in an *inpatient* or outpatient setting and include physical therapy, occupational therapy and speech therapy.

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 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*. Ambetter of Illinois insured by Celtic Insurance Company works with certified *hospice* programs licensed by the state to minimize patient discomfort and address the special physical, psychological, and social needs of *terminally ill members* and their *immediate family*.

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

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

Iatrogenic infertility means impairment of fertility by *surgery*, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

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 direct causes of a prior *illness*, the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

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

Immunosuppressant drugs mean drugs that are used in immunosuppressive therapy to inhibit or prevent the activity of the immune system. "*Immunosuppressant drugs*" are used clinically to prevent the rejection of transplanted organs and tissues. "*Immunosuppressant drugs*" do not include drugs for the treatment of autoimmune diseases or diseases that are most likely of autoimmune origin.

Infertility means a disease, condition, or status characterized by:
1. a failure to establish a *pregnancy* or to carry a *pregnancy* to live birth after 12 months of regular, unprotected sexual intercourse if the woman is 35 years of age or younger, or after 6 months of regular, unprotected sexual intercourse if the woman is over 35 years of age; conceiving but having a miscarriage does not restart the 12-month or 6-month term for determining *infertility*;
2. a person's inability to reproduce either as a single individual or with a partner without medical intervention; or

3. a licensed physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

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

Inpatient means that medical services, supplies, or treatment, for medical, *behavioral health* and *substance use 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.

Intoxicated means that which is defined and determined by the laws of jurisdiction where the *loss* or cause of the *loss* was incurred.

Licensed Mental Health Professional means a professional that holds a clinical license in a *behavioral health* discipline; and possesses the training or experience to complete the required evaluation and treatment of *behavioral health* disorders.

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

Low-dose Mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than one rad per breast for two views of an average size breast (also includes digital mammography).

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

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

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

Medical practitioner* or *other practitioner includes but is not limited to a *physician*, advanced practice nurse, *licensed mental health professional*, nurse anesthetist, *physician's* assistant, physical therapist, midwife, *rehabilitation licensed practitioner*, or registered surgical assistant. The following are examples of providers that are NOT *medical practitioners*, by definition of the *contract:* acupuncturist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, *emergency* medical technician, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

1. Is consistent with the symptoms or diagnosis;

2. Is provided according to *generally accepted 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 necessary medical supplies mean medical supplies that are:
1. *Medically 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.

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

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 the Ambulance Service Benefits provision under the **Medical Service Benefits** section for additional information.

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 the behavior, emotion or 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.

Network means a group of providers or facilities (including, but not limited to *hospitals*, *inpatient* mental health care 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 health care services to our *members* for an agreed upon fee. *Members* will receive most, if not all, of their health care 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 means any licensed person or entity that has entered into a contract with Ambetter of Illinois insured by Celtic Insurance Company 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 for:

1. *Emergency services*, as described in the Medical Service Benefits section of this *contract;*
2. Non-emergency health care services received at a *network* facility, as described in the Access to Care section of this *contract*; or
3. Situations otherwise specifically described in this *contract*.

Opioid antagonist means a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors.

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, 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, means a mental health or *substance use disorder* provider licensed/certified by the state in which care is being rendered and performing services within the scope of that license/certification.

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

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

Physician means a licensed *medical practitioner* who is practicing within the scope of his or her licensed authority in treating a bodily *injury* or *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 claimant 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 the *Schedule of Benefits*, if applicable, that must actually be paid during any calendar year before any *prescription drug* benefits are payable. The family *prescription drug deductible amount* is two times the individual *prescription drug deductible amount*. For family coverage, once a *covered person* has met the individual *prescription drug deductible amount*, any remaining family *prescription drug deductible amount* can be met with the combination of any one or more *covered persons' eligible expenses*.

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

Primary care physician (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 us. A *PCP* supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

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

Qualified health plan or ***QHP*** means a health plan that has in effect a certification that it meets the standards issued or recognized by each Health Insurance Marketplace through which such plan is offered.

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

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

Rehabilitation means care for restoration (including by education or training) of one's prior ability to function at a level of *maximum therapeutic benefit*. This includes *acute rehabilitation*, *sub-acute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy* and *cardiac rehabilitation 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.

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,* or nursing care.

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

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

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

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

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

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

Self-injectable drugs means *prescription drugs* that are delivered into a muscle or under the skin with a syringe and needle. Although medical supervision or instruction may be needed in the beginning, the patient or caregiver can administer *self-injectable drugs* safely and effectively.

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 Illinois to sell and market our health plans. This is where the majority of our *network* providers are located

where you will receive all of your health care services and supplies. You can receive precise *service area* boundaries from our website or our Member Services department.

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

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

Spouse means the person to whom you are lawfully married or, if you are a party to a *civil union* under the Illinois Religious Freedom Protection and Civil Union Act, the other party to such *civil union*.

Standard fertility preservation services means procedures based upon current evidence-based standard of care established by the American Society of Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

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 *contract*.

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.

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

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

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

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

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

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

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

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

Utilization review means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Areas of review may include ambulatory review, *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;*
2. The date of marriage to add a *spouse*;
3. The date of an eligible newborns birth;
4. The date that an adopted child is placed with the *subscriber* for the purposes of adoption, when an *eligible child* is placed in the custody of you and your *spouse* pursuant to an interim court order of adoption vesting temporary care of the child to you or your *spouse*, regardless of whether a final order granting adoption is ultimately issued or the *subscriber* assumes total or partial financial support of the child.

Effective Date for Initial Dependent Members
Dependent members included in the initial enrollment application for this *contract* will be covered on your *effective date*. If you apply in writing, or directly at enroll.ambetterhealth.com, for coverage on 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 card.

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

Additional premium will be required to continue coverage beyond the 31st day after the date of birth. Notice of the newborn must be given to us within 31 days after the date of birth in order to have the coverage continue after the 31 day period and will require payment of the additional premium. If notice is not given within the 31 days from birth, we will charge an additional premium from the date of birth. If notice is given by the Health Insurance Marketplace within 60 days of the birth of the child, we may not deny coverage of the child due to failure to notify us of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st day after its birth, unless we have received notice from the entity that you have enrolled with (either the Health Insurance Marketplace or us).

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

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

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

As used in this provision, *"placement"* means the assumption and retention by you or your *spouse* for total or partial support of the child in anticipation of the adoption of the child. Placement includes when an *eligible child* is placed in the custody of you or your *spouse* pursuant to an interim court order of adoption vesting temporary care of the child in you or your *spouse*, regardless of whether a final order granting adoption is ultimately issued.

Adding Other Dependent Members

If you are enrolled in an off-exchange *contract* and apply in writing, or directly at www.enroll.ambetterhealth.com, 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 the *subscriber* no longer resides or lives in the *service area* of this plan; 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 date of termination that the Health Insurance Marketplace provides us upon your request of cancellation to the Health Insurance Marketplace, or if you enrolled directly with us, the last day of the month we receive a request from you to terminate this *contract*, or any later date stated in your request will be effective the last day of the requested month but no further than 60 days in advance.

If you have material modifications (examples include a change in life event (marriage, death or family status), or questions related to your health insurance coverage, contact the Health Insurance Marketplace at www.healthcare.gov or 1-800-318-2596. If you enrolled through Ambetter contact Member Services Department: 1-855-745-5507 (TTY 1-844-517-3431).

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. "Discharge" means a formal release of a *member* from an *inpatient hospital* stay when the need for continued care at an *inpatient hospital* has concluded. Transfers from one *inpatient hospital* to another shall not be considered a discharge.

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

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*.

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

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

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

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

Open Enrollment
There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 1, 2022, and extends through January 15, 2023. *Qualified individuals* who enroll on or before December 15, 2022, will have an *effective date* of coverage on January 1, 2023.

The Health Insurance Marketplace may provide a coverage *effective date* for a *qualified individual* earlier than specified in the paragraphs above, provided that either:
1. The *qualified individual* has not been determined eligible for *advanced payments of the premium tax credit* or *cost sharing reductions*; or
2. The *qualified individual* pays the entire premium for the first partial month of coverage as well as all *cost sharing*, thereby waiving the benefit of *advanced payments of the premium tax credit* and *cost sharing reduction* payments until the first of the next month. We will send written annual open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

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

Qualifying events include:

1. A *qualified individual* or *dependent* experiences a loss of *minimum essential coverage*, non-calendar year group or individual health insurance coverage, *pregnancy*-related coverage, access to health care services through coverage provided to a pregnant *member's* unborn child, or medically needed coverage;
2. A *qualified individual* gains a *dependent* or becomes a *dependent* through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order. In the case of marriage, at least one *spouse* must demonstrate having *minimum essential coverage* as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage;
3. A *qualified individual* or *dependent*, who was not previously a citizen, national, or lawfully present individual gains such status; or who is no longer incarcerated or whose incarceration is pending the disposition of charges;
4. A *qualified individual's* enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or its instrumentalities as evaluated and are determined by the Health Insurance Marketplace;
5. A *member* or *dependent* adequately demonstrates to the Health Insurance Marketplace that the plan in which he or she is enrolled substantially violated a material provision of its *contract* in relation to the *member*;

6. A *qualified individual*, *member*, or *dependent*, adequately demonstrates to the Health Insurance Marketplace that a material error related to plan benefits, *service area*, or premium influenced the *qualified individual*'s or *member's* decision to purchase the *QHP*;
7. A *member* or *dependent* enrolled in the same plan is determined newly eligible or newly ineligible for *advanced premium tax credits* or has a change in *eligibility* for *cost sharing reductions*;
8. A *qualified individual* or *dependent* who is enrolled in an eligible employer-sponsored plan is determined newly eligible for *advanced premium tax credits* based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-2(c)(3);
9. A *qualified individual*, *member*, 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 60 days preceding the date of the permanent move;
10. A *qualified individual* or *dependent* who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a plan or change from one plan to another one time per month;
11. A *qualified individual* or *member* demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by the U.S. Department of Health and Human Services (HHS), that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide;
12. A *qualified individual*, *member*, or *dependent* is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B–2, and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
13. A *qualified individual* or *dependent* is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 days after the qualifying event; or applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;
14. A *qualified individual* newly gains access to an employer sponsored Individual Coverage Health Reimbursement Arrangement (ICHRA) (as defined in 45 CFR 146.123(b)) or a Qualified Small Employer Health Reimbursement Arrangement (QSHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code);
15. At the option of the Health Insurance Marketplace, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a plan through the Health Insurance Marketplace following termination of enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence; or
16. A *qualified individual* or dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions or government subsidies completely cease.
17. Subject to the availability of enhanced tax subsidies, a *qualified individual* or *member*, or their dependent who is eligible for advance payments of the premium tax credit, and whose household income is expected to be no greater than 150 percent of the Federal poverty level.

To determine if you are eligible and apply for a Special Enrollment Period, ***please visit Healthcare.gov and search for "special enrollment period."*** The Health Insurance Marketplace is responsible for all health care eligibility and enrollment decisions for *members* who enrolled via the Marketplace.

If you are currently enrolled in Ambetter of Illinois insured by Celtic Insurance Company, please contact

Member Services at 1-855-745-5507 (TTY 1-844-517-3431) with any questions related to your health insurance coverage.

Coverage Effective Dates for Special Enrollment Periods

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

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

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

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

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

If a *qualified individual*, *member*, or *dependent* did not receive timely notice of an event that triggers eligibility for a special enrollment period, and otherwise was reasonably unaware that a qualifying event occurred, the Health Insurance Marketplace must allow the *qualified individual*, *member*, or *dependent* to select a new plan within 60 days of the date that he or she knew, or reasonably should have known, of the occurrence of the triggering event. And at the option of a *qualified individual*, *member* or *dependent,* the Health Insurance Marketplace must provide the earliest effective that would have been available, based on the applicable qualifying event.

PREMIUMS

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

Grace Period
When a *member* is receiving a premium subsidy:
After the first premium is paid, a grace period of 90 days from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first 31 days of 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 31 days 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.

When a *member* is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 60 day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *contract* will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. We will notify the *member* of the non-payment of premiums, 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 will accept payments on the *member's* behalf from the following *third party* payers:

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. 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;
5. An employer for an employee under an ICHRA or QSEHRA plan; or
6. Family members.

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

Similarly, if we determine payment was made for *deductibles* or *cost sharing* by a *third party*, such as a drug manufacturer paying for all or part of a medication, that shall be considered a *third party* premium payment that will be counted towards your *deductible* or *maximum out-of-pocket amount*.

Misstatement of Age

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

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

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

COST SHARING FEATURES

Cost Sharing Features
We will pay benefits for *covered services* as described in the *Schedule of Benefits* and the *covered services* sections of this *contract*. All benefits we pay will be subject to all conditions, limitations, and *cost sharing* features of the *contract*. *Cost sharing* means that you participate or share in the cost of your health care 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 member*, 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*.

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

Coinsurance 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. Payment of a *coinsurance* amount does not exclude the possibility of a provider billing you for any non-*covered services*. *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.

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

Maximum Out-of-Pocket Amount
You must pay any required *copayments* or *coinsurance* amounts required until you reach the *maximum out-of-pocket amount* shown on your *Schedule of Benefits*. After the *maximum out-of-pocket amount* is met for an individual, we will pay 100 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 expense*s.

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

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

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

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

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

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

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

Emergent Services Only: if you receive emergent services from a *non-network provider*, you are responsible for an amount equal to your responsibility for similar services provided by a *network provider*. If you believe you have been billed in error, please contact Member Services at 1-855-745-5507 (TTY 1-844-517-3431).

ACCESS TO CARE

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

1. Family practitioners
2. General practitioners
3. Internal medicine
4. Nurse practitioners*
5. Physician assistants
6. Obstetricians/gynecologists
7. 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 *network providers*. See your *Schedule of Benefits* for more information.

You may obtain a list of *network PCP* 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:

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

Referral Required For Maximum Benefits
You do not need a referral from your *network PCP* for mental or *behavioral health* services, or obstetrical or gynecological treatment and may seek care directly from a *network* woman's principal health care provider. For all other *network specialist* providers, you are required to obtain a referral from your *network PCP.* If you have a condition that requires ongoing care from a *specialist* provider or other health care provider and a referral is required under this *contract*, you may request from your *PCP* a standing referral. A standing referral may be effective for up to one year and can be renewed if needed. You may contact us to learn more about the criteria and conditions related to obtaining a standing referral.

Contacting Your Primary Care Physician (PCP)
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 1-855-745-5507 (TTY 1-844-517-3431) 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. In an *emergency*, call 911 or head straight to the nearest *emergency* room.

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

Provider Contracts: Notice of Nonrenewal or Termination
We will provide at least 60 days' notice of nonrenewal or termination of a health care provider to the health care provider and to the *members* served by the health care provider. The notice shall include a name and address to which a *member* or health care provider may direct comments and concerns regarding the nonrenewal or termination. Immediate written notice may be provided without 60 days' notice when a health care provider's license has been disciplined by a State licensing board.

Non-Emergency Services
If you are traveling outside of the Ambetter of Illinois insured by Celtic Insurance Company *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 Illinois by searching the relevant state in our Provider Directory at Guide.AmbetterHealth.com. Not all states have Ambetter plans. If you receive care from an Ambetter provider outside of the *service area*, you may be required to receive *prior authorization* for non-*emergency services*. Contact Member Services at the phone number on your *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 the nearest *emergency* room. Be sure to a call us and report your *emergency* within one business day. You do not need prior approval for *emergency* care services.

Continuity of Care
Under the No Surprises Act, if a *member* is receiving a *covered service* with respect to a *network provider* or facility and: (1) the contractual relationship with the provider or facility is terminated, such that the provider or facility is no longer in *network*; or (2) benefits are terminated because of a change in the terms of the participation of the provider or facility, as it pertains to the benefit the *member* is receiving, then we will: (1) notify each *member* 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.

Hospital Based Providers
When receiving care at a *network hospital* it is possible that some *hospital*-based providers (for example, assistant surgeons, hospitalists, and intensivists) may not be under contract with us as *network 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 *non-network provider* in excess of the *eligible expense* will not apply to your *deductible amount* or *maximum out-of-pocket amount*.

You may not be *balance billed* for non-emergency ancillary services (emergency medicine, anesthesiology, pathology, radiology, and neonatology, as well as diagnostic services (including radiology and laboratory

services)) received from a *non-network provider* at a *network hospital* or *network* ambulatory facility.

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.

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

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

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

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

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*.

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

Coverage Under Other 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.*

MEDICAL SERVICE BENEFITS

The plan provides coverage for health care services for a *member* or covered *dependent member*. Some services require *prior authorization*. *Copayment, deductibles, and coinsurance amounts* must be paid to your *network provider* at the time you receive services. All *covered services* are subject to conditions, exclusions, limitations, terms and provisions of this *contract*. *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 under 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 of Illinois insured by Celtic Insurance Company will not pay benefits for any of the services, treatments, items or supplies that exceed benefit limits.

Ambulance Service Benefits (Ground)
Covered services will include ambulance services for ground and water transportation from home, scene of accident, or medical *emergency*:

1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*, in cases of *emergency*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.
3. Transportation between *hospitals* or between a *hospital* and skilled nursing or *rehabilitation facility,* and *member's* home when *authorized* by Ambetter of Illinois insured by Celtic Insurance Company.
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*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*.

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 medical transportation.
3. Ambulance services provided for a *member's* comfort or convenience.
4. Non-emergency transportation excluding ambulances.

Air Ambulance Service Benefits
Covered services will include ambulance services by fixed wing and rotary wing air ambulance from home, scene of accident, or medical emergency:

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

2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses, injuries*, congenital birth defects, or complications of premature birth that require that level of care.
3. Transportation between *hospitals* or between a *hospital* and a skilled nursing, *rehabilitation facility,* and *member's* home when *authorized* by Ambetter of Illinois insured by Celtic Insurance Company.
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* air ambulance transportation. Please note: You should not be *balance billed* for services from a *non-network* ambulance provider, beyond your *cost share*, for air ambulance services.

Limitations: Benefits for air ambulance services are limited to:
1. Services requested by police or medical authorities at the site of an *emergency*.
2. Those situations in which the *member* is in a location that cannot be reached by ground ambulance.

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

Exclusions:
No benefits will be paid for:
1. Expenses incurred for air 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 air 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 *network behavioral health* providers by using the "Find a Provider" function at AmbetterofIllinois.com or by calling Member Services at 1-855-745-5507 (TTY 1-844-517-3431). *Deductible amounts*, *copayment* or *coinsurance* amounts and treatment limits for covered *mental health* and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

Covered services for mental health and *substance use disorder* are included on a non-discriminatory basis for all *members* for the diagnosis and *medically necessary* treatment of mental, emotional, or *substance use disorders* as defined in this *policy*.

When making coverage determinations, our *behavioral health* and *substance use disorder* 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. *Inpatient rehabilitation*;
4. Crisis stabilization;
5. *Residential treatment facility* for mental health and *substance use disorder*; and
6. Electroconvulsive therapy (ECT).

Outpatient

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

In addition, Integrated *Care Management* is available for all of your health care needs, including *behavioral health* and *substance use disorder*. Please call 1-855-745-5507 (TTY 1-844-517-3431) to be referred to a care manager for an assessment.

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

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

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.

Outpatient and *inpatient* treatment provided for *substance use disorders* requires notification from the treating provider within 24 hours* of initiation of treatment. If the provider or facility fails to provide us with notification accordingly, *prior authorization* processes may be implemented.

*Note: For managed care organizations, the *substance use disorder* treatment provider or facility notification shall occur in accordance with the protocol set forth in the provider agreement for initiation of treatment within 24 hours. If the managed care organization is not capable of accepting the notification in accordance with the contractual protocol during the 24-hour period following admission, the substance use disorder treatment provider or facility shall have one additional business day to provide the notification to the appropriate managed care organization.

Habilitation Expense Benefits
Covered service expenses provided for *medically necessary habilitation services* shall include:

1. Outpatient physical *rehabilitation* services including speech and language therapy and/or occupational therapy, performed by a licensed therapist.
2. Clinical therapeutic intervention defined as therapies supported by empirical evidence, which include but are not limited to *applied behavior analysis*, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the services in accordance with a treatment plan.
3. Mental/*behavioral health outpatient services* performed by a licensed psychologist, psychiatrist, or *physician* to provide consultation, assessment, development and oversight of treatment plans.

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

Habilitative Services for Children
Covered service expenses provided for habilitative services for children through age 19 with a congenital, genetic, or early acquired disorder so long as all of the following conditions are met:

1. A physician licensed to practice medicine in all its branches has diagnosed the child's congenital, genetic, or early acquired disorder.
2. The treatment administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, licensed physician, licensed nurse, licensed optometrist, licensed nutritionist, licensed social worker, or licensed psychologist upon the referral of a physician licensed to practice medicine in all its branches.

The initial or continued treatment must be *medically necessary* and therapeutic and not *experimental or investigational*.

This *contract* will not deny *medically necessary* habilitative services for children solely because of the location wherein the clinically appropriate services are provided.

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

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

- evaluation and assessment services;
- *applied behavior analysis* therapy;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy;
- psychiatric care such as counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor or clinical social worker; and

- medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

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

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

1. *Home health aide services* only if provided in conjunction with skilled registered nurse or licensed practical nursing services.
2. Skilled services of a registered nurse or licensed practical nurse rendered on an outpatient basis.
3. Services of a private duty registered nurse rendered on an outpatient basis.
4. 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.
5. Intravenous medication and pain medication to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.
6. Hemodialysis, and for the processing and administration of blood or blood components.
7. *Medically necessary medical supplies*.
8. *Hospital* laboratory services to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.
9. 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 from a *network provider* in lieu of its rental if the rental price is projected to exceed the equipment purchase price.

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

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

Hospice Care Service Expense Benefits
Hospice care benefits are allowed for a *member* that has a terminal *illness* with a life expectancy of one year or less, as certified by your *attending physician*, and you will no longer benefit from standard medical care or have chosen to receive *hospice* care rather than standard care. *Covered services* include:

1. Room and board in a *hospice* while the *member* is an *inpatient.*
2. Coordinated home care.
3. Medical supplies and dressings.
4. Medications.
5. Skilled and non-skilled nursing services.
6. Physical and occupational therapy.
7. Speech-language therapy.
8. *Physician* visits.
9. 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.*
10. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
11. Counseling the *member* regarding his or her *terminal illness.*
12. *Terminal illness counseling* of the *member's immediate family.*

13. *Bereavement counseling.*
14. *Respite care* services.

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

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

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

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 (CT scan),), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT), mammogram, and ultrasound imaging). *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).

Rehabilitation and Skilled Nursing Facility Expense Benefits

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

1. *Covered service expenses* available to a *member* while confined primarily to receive *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility or skilled nursing 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 skilled nursing facility for:
    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    c. Drugs and medicines that are prescribed by a *physician,* filled by a licensed pharmacist, and approved by the U.S. Food and Drug Administration.
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners.*
5. Outpatient physical therapy, occupational therapy, respiratory, pulmonary or inhalation therapy and speech therapy.

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 measurable progress toward documented goals.
4. Care is primarily *custodial care*.

Long Term Acute Care Hospital

Long-term acute care *hospitals* (LTACHs) furnish extended medical and rehabilitative care to individuals with clinically complex problems, such as multiple acute or chronic conditions, that need *hospital*-level care for relatively extended periods.

Common conditions/services that may be considered *medically necessary* for LTACH level of care included, but not limited to:

- Complex wound care:
  - Daily *physician* monitoring of wound
  - Wound requiring frequent complicated dressing changes, and possible repeated debridement of necrotic tissue
  - Large wound with possible delayed closure, draining, and/or tunneling or high output fistulas
  - Lower extremity wound with severe ischemia
  - Skin flaps and grafts requiring frequent monitoring
- Infectious disease:
  - Parenteral anti-infective agent(s) with adjustments in dose
  - Intensive sepsis management
  - Common conditions include osteomyelitis, cellulitis, bacteremia, endocarditis, peritonitis, meningitis/encephalitis, abscess and wound infections
- Medical complexity:
  - Primary condition and at least two other actively treated co-morbid conditions that require monitoring and treatment
  - Common conditions include metabolic disorders, stroke, heart failure, renal insufficiency, necrotizing pancreatitis, emphysema (COPD), peripheral vascular disease, and malignant/end-stage disease
- *Rehabilitation*:
  - Care needs cannot be met in a *rehabilitation* or skilled nursing facility
  - Patient has a comorbidity requiring acute care
  - Patient is able to participate in a goal-oriented *rehabilitation* plan of care
  - Common conditions include CNS conditions with functional limitations, debilitation, amputation, cardiac disease, orthopedic *surgery*
- Mechanical ventilator support:
  - Failed weaning attempts at an acute care facility
  - Patient has received mechanical ventilation for 21 consecutive days for 6 hours or
  - more/day
  - Ventilator management required at least every 4 hours as well as appropriate diagnostic services and assessments
  - Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions
  - Patient is hemodynamically stable and not dependent on vasopressors
  - Respiratory status is stable with maximum PEEP requirement 10 cm H2O, and FiO2 60 percent or less with O2 saturation at least 90 percent
  - Common conditions include complications of acute lung *injury*, disorders of the central nervous and neuromuscular systems, and cardiovascular, respiratory, and pleural/chest wall disorders
- Patient continues to meet the criteria above and does not meet the criteria to be transitioned to alternate level of care.

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.

Respite Care *Expense Benefits*
Respite care is covered on an *inpatient* or home basis to allow temporary relief to family members from the duties of caring for a *covered person* who is undergoing under *hospice* care. Respite days that are applied toward the *member's cost share* obligations are considered benefits provided and shall apply against any maximum benefit limit for these services. See your *Schedule of Benefits* for coverage limits.

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

Exclusions:
No benefits will be paid for any other non-medical dietary formulas, oral nutritional supplements, special diets, prepared foods/meals and formula for access problems.

Chiropractic and Osteopathic Services
We cover charges for chiropractic and osteopathic services. These services shall be provided at the request of the *member* who presents a condition of an orthopedic or neurological nature necessitating treatment for which falls within the scope of a licensed chiropractor or osteopath. See your *Schedule of Benefits* for benefit levels or additional limits.

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.

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

1. Daily room and board and nursing service, not to exceed the *hospital*'s most common semi-private room rate.
2. Daily room and board and nursing services while confined in an *intensive care unit*.
3. *Inpatient* use of an operating, treatment, or recovery room for *surgery*.
4. Outpatient use of an operating, treatment, or recovery room for *surgery*.

5. Services and supplies, including drugs and medicines, which are routinely provided by the *hospital* to persons for use only while they are *inpatients*.
6. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See your *Schedule of Benefits* for limitations.
7. A private *hospital* room when needed for isolation.

If you receive emergent services from a *non-network provider*, you are responsible for an amount equal to your responsibility for similar services provided by a *network provider*. If you believe you have been billed in error, please contact Member Services at 1-855-745-5507 (TTY 1-844-3431).

Urgent Care
Urgent Care services include *medically necessary* services by *network providers* and services provided at an *urgent care center* including facility costs and supplies. Care that is needed after a *PCP'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 *PCP* 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 *PCP* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-855-745-5507 (TTY 1-844-3431). The 24/7 Nurse Advice Line is available 24 hours a day, 7 days a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

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

Medical and Surgical Expense Benefits
Medical *covered service expenses* are limited to charges:
1. For *surgery* in a *physician's* office or at an *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, ultrasonographic, or laboratory services.
5. For chemotherapy and radiation therapy or treatment.
6. For the cost and administration of an anesthetic.
7. For oxygen and its administration.
8. For accidental *dental service expenses* related specifically and directly to a medical condition.
9. For *dental service expenses* when a *member* suffers an *injury,* after the *member's effective date* of coverage, that results in:
    a. Accidental damage to his or her natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *health care professional* and began within 12 months of the accident to be considered as a *covered service*.
    c. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
10. Oral *surgery*/TMJ services and devices, limited to:
    a. surgical removal of complete bony impacted teeth;
    b. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
    c. *surgical procedures* to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
    d. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

11. 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 will include: *inpatient* treatment following mastectomy for length of time to be determined by *attending physician*; and availability of post-discharge *physician* office visit or in-home nurse visit within 48 hours of discharge. Coverage includes all *medically necessary* pain medication and pain therapy related to the treatment of breast cancer. As used here, "pain therapy" means pain therapy that is medically based and includes reasonably defined goals, including, but not limited to, stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals.
12. For *medically necessary* services and supplies used in the treatment of persons with gestational, type I or type II diabetes*. Covered service expenses* include, but are not limited to, 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 and/or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; insulin pumps; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.
13. For the following types of tissue transplants:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.
    e. Implantable prosthetic lenses, in connection with cataracts.
14. Family planning for certain professional provider contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices. Medical history review, physical examinations, laboratory tests related to physical examinations, contraceptive counseling and all FDA-approved contraception methods are covered. This benefit contains both pharmaceutical and medical methods, including: intrauterine devices (IUD), including insertion and removal; barrier methods including: condoms (Rx required from provider, limited to 30 per month), diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide and spermicide alone; oral contraceptives including the pill (combined pill and extended/continuous use), and the mini pill (Progestin only), patch; other hormonal contraceptives, including inserted and implanted contraceptive devices, hormone contraceptive injections and the vaginal contraceptive ring; emergency contraception (the morning after pill). Medical history review, physical examinations, laboratory tests related to physical examinations, contraceptive counseling and all FDA-approved contraception methods are covered.
15. Allergy testing, injections and serum.
16. X-ray and other radiology services.
17. Magnetic Resonance Imaging (MRI).
18. CT scans.
19. Positron emission tomography (PET scanning).
20. Coverage for a complete and thorough clinical breast examination for the purpose of early detection and prevention of breast cancer at the following intervals:
    a. At least every 3 years for *members* 20 years of age and under 40 years of age; and
    b. Annually for *members* 40 years of age or older.

    Coverage include services provided by a *physician,* an advanced practice nurse who has a collaborative agreement with a collaborating *physician* that *authorizes* breast examinations or a *physician* assistant who has been delegated authority to provide breast examinations.
21. 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. the *member* is under the age of five;
    b. the *insured person* has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided; or

c. the *member* is severely disabled. Disabled means a *member*, regardless of age, with a chronic disability if the chronic disability meets all of the following conditions. It is attributable to a mental or physical impairment or combination of mental and physical impairments:
    a. It is likely to continue;
    b. It results in substantial functional limitations in one or more of the following areas of major life activity:
        - self-care;
        - receptive and expressive language;
        - learning;
        - mobility;
        - capacity for independent living; or
        - economic self-sufficiency.

22. Following a recommendation for elective *surgery*. Coverage will be provided at 100 percent of claim charge for one consultation and related diagnostic service by a *physician*. If requested, benefits will be provided for an additional consultation when the need for *surgery*, in your opinion, is not resolved by the first consultation.
23. Coverage for outpatient end stage renal disease treatment including both outpatient and in-patient settings based on medical necessity.
24. Coverage for any *emergency*, other medical or *hospital* expense, if *member* is *intoxicated* or under the influence of any narcotic, regardless of whether the intoxicant or narcotic is administered on the advice of a health care practitioner.
25. Coverage for routine physical examinations for expenses incurred in the examination and testing of a victim of a criminal sexual assault or abuse from a *network provider* or a *non-network provider*. No *cost sharing* will apply.
26. Covered expenses include an annual digital rectal examination and "prostate-specific antigen tests" performed to determine the level of prostate specific antigen in the blood for covered person who is at least fifty (50) years of age; and at least once annually for a covered person who is less than fifty (50) years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.
27. *Medically necessary* treatment for varicose and spider veins treatment.
28. Bariatric *surgery*.
29. For naprapathic services. See your *Schedule of Benefits* for benefit levels or additional limits.
30. Preventive services for the treatment of obesity.
31. Coverage for *durable medical equipment.*
32. For *medically necessary* genetic blood tests i.
33. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
34. *Medically necessary telehealth services* subject to the same clinical and *utilization review* criteria, plan requirements and limitations as the same health care services when delivered to an insured in person. *Telehealth services* provided by *Ambetter Telehealth* are subject to $0 *copay*. *Telehealth services* not provided by *Ambetter Telehealth* would be subject to the same *cost sharing* as the same health care services when delivered to a *member* 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.
35. Preadmission testing.
36. Coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome, including, but not limited to, the use of intravenous immunoglobulin therapy.
37. For *medically necessary* examination, testing, and antibiotic therapy for tick-borne disease.
38. For respiratory and pulmonary therapy.
39. For the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive

chemotherapy/autologous bone marrow transplants or stem cell transplants.

40. For cancer screenings, as follows:
    a. A pelvic examination and pap smear for any non-symptomatic woman who is a *member*, in accordance with the current American Cancer Society guidelines;
    b. A prostate examination and laboratory tests for cancer for any non-symptomatic man who is a *member*, in accordance with the current American Cancer Society guidelines;
    c. A colorectal cancer examination and laboratory tests for cancer for any non-symptomatic *member*, in accordance with the current American Cancer Society guidelines, starting at age 45 (**note**: screening should start before age 45 for high risk individuals); and
41. For *medically necessary* diagnostic and laboratory and x-ray tests.
42. 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.
43. For scalp hair prosthesis expenses for hair loss suffered as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia, or permanent loss of scalp hair due to *injury*. Such coverage shall be subject to a written recommendation by the treating health care professional stating that the hair prosthesis is a medical necessity.
44. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, or malocclusions.
45. For pulse oximetry screening on a newborn.
46. Well Childcare 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.
47. Newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.
48. 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.
49. 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.
50. 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.
51. Testing of pregnant women and other *members* for lead poisoning.
52. For *medically necessary* vitamin D testing when recommended from a *network provider* and in accordance with vitamin D deficiency risk factors identified by the United States Centers for Disease Control and Prevention (CDC).
53. *Medically necessary* routine foot care, *prior authorization* may be required.
54. Male sterilization services are covered at no cost when services are rendered by a *network* provider.

Fertility Preservation Services

Coverage for *medically necessary* expenses for *standard fertility preservation services* when a necessary medical treatment may directly or indirectly cause *iatrogenic infertility* to a *member*.

Infertility Expense Benefits

Infertility coverage for the diagnosis and treatment of *infertility* including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, oocyte retrieval and intracytoplasmic sperm injection.

Coverage for procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer shall be required only if:

1. The *member* has been unable to attain or sustain a successful *pregnancy* through reasonable, less costly medically appropriate *infertility* treatments for which coverage is available under the *contract*;
2. The *member* has not undergone four completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals will be covered; and
3. The procedures are performed at medical facilities that conform to the American College of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

Dialysis Services

Medically necessary acute and chronic dialysis services are *covered services* unless other coverage is primary, such as Medicare for dialysis. Provided you meet all the criteria for treatment, there are two types of treatment options. 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:
- Services provided in an outpatient dialysis facility or when services are provided in the home;
- Processing and administration of blood or blood components;
- Dialysis services provided in a *hospital*;
- Dialysis treatment of an acute or chronic kidney ailment which may include the supportive use an artificial kidney machine.

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

Diabetic Care

For *medically necessary* services and supplies used in the treatment of persons with gestational, type I or type II diabetes*. Covered service expenses* include, but are not limited to, *medically necessary telehealth services;* 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; prescription medication; and one retinopathy examination screening per year.

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

- The equipment, supply or appliance is a *covered service*;

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

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

Benefits for repairs and replacement do not include the following:
1. Repair and replacement due to misuse, malicious breakage or gross neglect.
2. Replacement of lost or stolen items.

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

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

Covered services may include, but are not limited to:
1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for IV fluids and medicine.
5. Glucometer.
6. Tracheotomy tube.
7. Cardiac, neonatal and sleep apnea monitors.
8. Augmentive communication devices are covered when we approve based on the *member's* condition.

Exclusions:
Non-covered items may include but are not limited to:
1. Air conditioners.
2. Ice bags/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. Cochlear implants, bone anchored hearing aids, and related fittings.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (the first one following cancer treatment, not to exceed one per benefit period), when purchased through a *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).

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

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

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

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 of Illinois Provider Directory. If a *member* chooses a *network provider*, he or she will only be responsible for the applicable *copayment amount* for the consultation. Any lab tests and/or diagnostic and therapeutic services are subject to 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.

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

Social Determinants of Health Supplemental Benefits
Social determinants of health supplemental benefits and services may be offered to *members* to remove barriers to accessing health services and improve overall health outcomes. These are benefits and services that we may make available in connection with this *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 *members* are eligible for the benefits upon obtaining coverage. The services are optional, and the benefits are made available at no additional cost to the *member*. 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 *members* through the "My Health Pays" wellness program and through our website. *Members* 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 AmbetterofIllinois.com or by contacting Member Services at 1-855-745-5507 (TTY 1-844-517-3431).

Outpatient Medical Supplies Expense Benefits
Covered expenses for outpatient medical supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs (but not the replacement thereof, unless required by a physical change in the *covered person* and the item cannot be modified). If more than one *prosthetic device* can meet a *covered person's* functional needs, only the charge for the most cost effective *prosthetic device* will be considered a *covered expense*.
2. For one pair of foot orthotics per year per *covered person*.
3. For four mastectomy bras per year if the *covered person* has undergone a covered mastectomy.
4. For rental of *medically necessary durable medical equipment*.
5. For the rental of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint *surgery*.
6. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract *surgery*. See your *Schedule of Benefits* for benefit levels or additional limits.
7. *Medically necessary* amino acid-based elemental formula for the diagnosis and treatment of (i) eosinophilic disorders and (ii) short bowel syndrome when prescribed by a *physician*.
8. Contraceptive coverage for a *member* and any *dependent member* for all FDA-approved contraception methods are approved for *members* without *cost sharing* as required under the *Affordable Care Act*. *Members* have access to the methods available and outlined on our drug *formulary* or Preferred Drug List without *cost share*. The *formulary* includes coverage for prescription and over the counter oral contraceptive products. In accordance with Illinois law, we allow for 12 month supply of oral contraceptives dispensed at one time. Some contraception methods are available through a *member's* medical benefit, including the insertion and removal of the contraceptive device at no *cost share* to the *member*. Emergency contraception is available to *members* without a prescription and at no *cost share* to the *member*.

9. Shingles coverage for a vaccine for shingles that is approved for marketing by the Federal Food and Drug Administration if the vaccine is ordered by a *physician* licensed to practice medicine in all its branches and the *member* is 60 years of age or older.
10. Coverage for Preventive Physical Therapy for Multiple Sclerosis Patients. As used here, "preventive physical therapy " means physical therapy that is prescribed by a *physician* licensed to practice medicine in all of its branches for the purpose of treating parts of the body affected by multiple sclerosis, but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.
11. Coverage for pulmonary *rehabilitation therapy*.
12. Coverage for cardiac outpatient *rehabilitation* services.
13. Coverage for osseointegrated auditory implants.
14. Routine hearing exams and hearing aids. See your *Schedule of Benefits* for benefit levels and any applicable limits.

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 provision are limited to charges from a licensed *pharmacy* for:

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

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

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

Such *covered service expenses* shall include those for prescribed, orally administered anticancer medications. The *covered service expenses* shall be no less favorable than for intravenously administered or injected cancer medications that are covered as medical benefits under this *contract*.

Non-Covered Services 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 listed on the *formulary*.
2. For weight loss *prescription drugs* unless otherwise listed on the *formulary*.
3. For immunization agents otherwise not required by the Affordable Care Act.
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 more than a 30-day supply when dispensed in any one prescription or refill, or for maintenance drugs up to 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply *network*. Specialty drugs and other select drug categories are limited to a 30-day supply when dispensed by retail or mail order. Please note that only the 90-day supply is subject to the discounted *cost sharing*. Mail orders less than 90-days are subject to the standard *cost sharing* amount.
11. 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.
12. For any drug that we identify as therapeutic duplication through the Drug *Utilization Review* program.
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 any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
15. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventive treatment is related to *member's* vacation during out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
16. For medications used for cosmetic purposes.
17. For *infertility* drugs unless otherwise listed on the *formulary*.
18. 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.
19. For any drug related to dental restorative treatment or treatment of chronic periodontitis, while drug administration occurs at dental practitioner's office.
20. For any claim submitted by a non-lock-in pharmacy while *member* is in a 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 the *member's* place of *residence* unless listed on the *formulary*.
23. For any prescription or over-the-counter version of vitamin(s) unless otherwise included on the *formulary*.
24. Medication refills where a *member* has more than 15 days' supply of medication on hand.
25. For compound drugs, unless there is at least one ingredient that is an FDA approved drug.

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.

Maximum Insulin Medication Cost Share:
Insulin medications are covered with a maximum *cost share* of $100 per 30-day supply. If your *cost share* per 30-day supply of insulin medications is less than $100, you will be responsible for the lower amount. Please refer to our *formulary* for tier placement of insulin medications and your *Schedule of Benefits* for your *cost share* responsibility for the associated drug tier.

Special Rules for *Prescription Drug* Coverage:

1. The financial requirements applicable to orally-administered cancer medications may be no different than those same requirements applied to intravenously administered or injected cancer medications.
2. Coverage for prescribed drugs for certain types of cancer shall not exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration if proper documentation, as outlined, is provided. Such coverage shall also include those *medically necessary* services associated with the administration of such drugs.

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

Formulary or Prescription Drug List
The *formulary* or *prescription drug* list is a guide to available generic and 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 *formulary* or *prescription drug* list or for more information about our pharmacy program, visit AmbetterofIllinois.com (under "For Member", "Drug Coverage") or call Member Services at 1-855-745-5507 (TTY 1-844-517-3431).

Formulary includes coverage for opioid Medical Assisted Treatment (MAT) products, intranasal opioid reversal agents, topical anti-inflammatory medications for acute and chronic pain, and epinephrine injectors.

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.

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

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 Provider Directory to find a pharmacy near you. You can access the Provider Directory at AmbetterofIllinois.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 *network* retail pharmacies for specific benefit plans. These drugs treat long-term conditions or *illnesses*, such as high blood pressure, asthma and diabetes. You can find a list of covered medications on AmbetterofIllinois.com. You can also request to have a copy mailed directly to you.

Extended Days' Supply
Maintenance medications are generally taken daily for chronic and lifelong conditions. Extended days' supply fills of select maintenance medications are available exclusively at CVS Mail Order. Members obtaining a 90-day fill via CVS Mail Order will pay only 2.5 times their standard retail cost sharing.

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

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

Mail Order Pharmacy
If you have more than one prescription you take regularly, you may select to enroll in our mail order delivery program. Your prescriptions will be safely delivered right to your door at no extra charge to you. You will still be responsible for your regular *copayment/coinsurance*. To enroll for mail order delivery or for any additional questions, call our mail order pharmacy at 1-888-624-1139. Alternatively, you can fill out an enrollment form and mail the form to the address provided at the bottom of the form. The enrollment form can be found on our website. Once on our website, click on the section, “For Member,” “Drug Coverage.” The enrollment form will be located under “Forms.”

Prescription Drug Synchronization
Under Illinois law you have the right to request synchronization of your medications. Synchronization is alignment of your fill dates so that all of your medication-refill dates are on the same day. For example, if you fill medication A on the 5th of each month and your prescriber prescribes you a new prescription B on the 20th of the month, you have the right to request a refill for prescription B that is shorter or longer than 30 days. This may help you adjust your fill dates for medication B and synchronize the fill dates with medication A. We will adjust *Copays* to reflect shorter or longer coverage. If you would like to exercise this right, please call our customer service line.

Step Therapy 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.

Self-injectable Drugs
Self-injectable drugs are delivered into a muscle or under the skin with a syringe and needle. Although medical supervision or instruction may be needed in the beginning, the patient or caregiver can administer *self-*

injectable drugs safely and effectively. *Self-injectable drugs* are covered under the *prescription drug* benefits; *prescription drug* cost share applies.

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:
    b. has been ineffective in the treatment; or
    c. has caused an adverse reaction or harm to a *member*.

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.

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 *member's* life, health, or ability to regain maximum function or when a *member* 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 standard exception request be granted, we will provide coverage of the non-*formulary* drug for the duration of the exigency.

External exception request review

If we deny a request for a standard exception or for an expedited exception, the *member*, the *member's 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 its receipt of the request, if the original request was an expedited exception.

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

Lock-In Program

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

Third Party Payments for Prescriptions

Any *third party* payments, financial assistance, discount, product vouchers, or any other reduction in out-of-

pocket expenses made by or on behalf of a *member* for *prescription drugs* will be applied to your *deductible, copayment*, *cost sharing* or *maximum out-of-pocket amount*.

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 *member* 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.

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

Wellness and Other Program Benefits

Benefits may be available to *members* for participating in certain programs that we may make available in connection with this *contract*. Such programs may include wellness programs and 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 AmbetterofIllinois.com or by contacting Customer Service by telephone at 1-855-745-5507 (TTY 1-844-517-3431). The benefits are available as long as coverage remains active, unless changed by us as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All *members* are eligible for program benefits upon obtaining coverage. The programs are optional, and the benefits are made available at no additional cost to the *member*. 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. A reasonable alternative will be made available to any individual for whom it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards.

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:

1. Better understand and manage your health conditions
2. Coordinate services
3. 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 *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 1-855-745-5507 (TTY 1-844-517-3431).

Pediatric Vision Expense Benefits

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

1. Routine ophthalmological exam
    a. Refraction;
    b. Dilation;
2. 2. Contact lens fitting.
    a. 3. 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 evaluation/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 AmbetterofIllinois.com or call Member Services at 1-855-745-5507 (TTY 1-844-517-3431).

Services not covered:

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

Medically Necessary Vision Services

Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by a *network provider* (optometrist or ophthalmologist). *Covered services* include office visits, testing, and treatment of eye conditions producing symptoms that if left untreated may result in the loss of vision.

Excluded services for routine and non-routine vision include:

1. Visual therapy.
2. Any vision services, treatment or materials not specifically listed as a *covered service*.
3. Low vision services and hardware for adults.
4. Non-*network* care, except for pre-*authorized*.

Routine Vision Benefits – Adults 19 years of age or older

Coverage for vision services is provided for adults, age 19 and older.

1. Routine ophthalmological exam
    a. Refraction;
    b. Dilation;
    c. Contact lens fitting.
2. Frames
3. Prescription lenses
    a. Single;
    b. Bifocal;
    c. Trifocal;
    d. Lenticular; or
    e. Contact lenses (in lieu of glasses).

Please refer to your *Schedule of Benefits* for a detailed list of *cost sharing*, annual maximum and appropriate service limitations. To see which vision providers are part of the *network*, please visit AmbetterofIllinois.com or call Member Services at 1-855-745-5507 (TTY 1/844-517-3431).

Services not covered:

1. Visual therapy;
2. Low vision services and hardware for adults;
3. LASIK *surgery*.

Dental Benefits – Adults 19 years of age or older

Coverage for *dental services* is provided for adults, age 19 and older, for Diagnostic and Preventive , Basic Services and Major Services rendered by dental providers.

1. Diagnostic and Preventive —Class 1 benefits include:
    a. Routine cleanings;
    b. Oral exams;
    c. X-rays – bite-wing, full-mouth and panoramic film;
    d. Topical fluoride application.
2. Basic Services— Class 2 benefits include:
    a. Minor restorative – metal fillings or resin-based;
    b. Endodontics – root canals;
    c. Periodontics – scaling and root planing; periodontal maintenance;
    d. Simple Extractions – routine and surgical; and
    e. Removable Prosthodontics – relines, rebase, adjustment and repairs.
3. Major Services—Class 3 benefits include:
    a. Crowns and bridges;
    b. Dentures;
    c. Impactions, 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 AmbetterofIllinois.com or call Member Services at 1-855-745-5507 (TTY 1-844-517-3431).

Services not covered:

1. *Dental services* that are not necessary or specifically covered;
2. Hospitalization or other facility charges;
3. *Prescription drugs* dispensed in the dental office;
4. Any dental procedure performed solely as a cosmetic procedure;
5. Charges for dental procedures completed prior to the *member's effective date* of coverage;
6. Services provided by an anesthesiologist;
7. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by abrasion, abfraction, or erosion, realignment of teeth, periodontal splinting, and gnathologic recordings;
8. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles;
9. Any artificial material implanted or grafted into soft tissue or bone, surgical removal of implants, and implant-related services;
10. Sinus augmentation;
11. Surgical appliance removal;
12. Intraoral placement of a fixation device;
13. Oral hygiene instruction, tobacco counseling, nutritional counseling, or high-risk substance use counseling;
14. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture;
15. Any oral *surgery* that includes surgical endodontics (apicoectomy and retrograde filling);
16. Analgesia (nitrous oxide);
17. Removable unilateral dentures;
18. Temporary procedures;
19. Splinting;
20. Temporal Mandibular Joint disorder (TMJ) appliances, therapy, films and arthorograms;
21. Oral pathology laboratory charges;
22. Consultations by the treating provider and office visits;
23. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);

24. Veneers (bonding of coverings to the teeth);
25. Orthodontic treatment procedures;
26. Orthognathic *surgery*;
27. Athletic mouth guards; and
28. Space maintainers.

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 *network hospital*, surgical center or office, provided to the following members:
    a. A *member* under the age of 19;
    b. A person who is severely disabled; or
    c. A person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.
3. For *dental service* expenses when a member suffers an *injury*, that results in:
    a. Damage to his or her natural teeth;
    b. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
4. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, or malocclusions.

Preventive Care Expense Benefits

Preventive care services are covered as required by the *Affordable Care Act (ACA)*. According to the ACA, preventive care services must include the following:

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 (USPSTF;
2. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation

from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC);
3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
4. With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by HRSA.

Preventive care benefits obtained from a *network provider* are covered without *member* cost share (i.e., covered in full without deductible, coinsurance or copayment). For current information regarding available preventive care benefits, please access the Federal Government's website at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

Preventive care refers to services or measures taken to promote health and early detection or prevention of diseases and injuries, rather than treating or curing them. Preventive care includes, but is not limited to, immunizations, medications, tobacco cessation treatment, examinations and screening tests tailored to an individual's age, health and family history.

Certain services can be performed for preventive or diagnostic reasons (e.g., mammograms). If a service is deemed preventive care and is appropriately reported/billed, it will be covered under the preventive care services benefit. However, when a service is performed for diagnostic purposes and reported/billed accordingly, it will be considered a non-preventive medical benefit and appropriate cost share will apply. **Note**: If preventive and diagnostic services are performed during the same visit, applicable cost share will be taken for the latter.

As new preventive care recommendations and guidelines are issued (by the USPSTF, CDC or HRSA), those services will become covered preventive care benefits. According to the *ACA*, coverage of new recommendations and guidelines become effective upon a plan's start or anniversary date that is one year after the date the recommendation or guideline is issued.

Note: In addition to providing coverage in accordance with the *ACA*, we also provide preventive care benefits in accordance with applicable State law.

Notification
As required by section 2715(d)(4) of the Public Health Service Act, we will provide 60 days advance notice to you before any material modification will become effective, including any changes to preventive benefits covered under this *contract*. You may access our website or the Member Services Department at 1-855-745-5507 (TTY 1-844-517-3431) to get the answers to many of your frequently asked questions regarding preventive services. Our website has resources and features that make it easy to get quality care. Our website can be accessed at ambetterofillinois.com.

Covered Preventive Services for Adults including:
1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked;
2. Alcohol misuse screening and counseling;
3. Aspirin use for *members* of certain ages;
4. Blood pressure screening for all adults;
5. Cholesterol screening for adults of certain ages or at higher risk;
6. Colorectal cancer screening for adults over age 45 (**note**: screening should start before age 45 for high risk individuals);
7. Depression screening for adults;
8. Diabetes screening for adults with high blood pressure;
9. Diet counseling for adults at higher risk for chronic disease;

10. HIV screening and counseling for all adults at higher risk;
11. Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
    - Haemophilus influenza type b (HIB)
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza (Flu Shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella;
12. Obesity screening and counseling for all adults;
13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;
14. *Tobacco or nicotine use* screening for all adults and cessation interventions for tobacco or nicotine users;
15. Syphilis screening for all adults at higher risk;
16. Falls prevention in older adults, exercise or physical therapy. The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls;
17. Falls prevention in older adults: vitamin D. The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls;
18. Hepatitis B screening: non-pregnant adolescents and adults. The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection;
19. Hepatitis C virus infection screening: adults. The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965;
20. Lung cancer screening. The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung *surgery*;
21. Haemophilus influenza type b (HIB) one or three doses;
22. Skin cancer behavioral counseling. The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer;
23. Tuberculosis screening: adults. The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk; and
24. Whole body skin examination for the detection of skin cancer.

Covered Preventive Services for Women and Pregnant Women include:

1. Anemia screening on a routine basis for pregnant *members*;
2. Bacteriuria urinary tract or other infection screening for pregnant *members*;
3. BRCA counseling and risk assessment about genetic testing for *members* at higher risk;
4. One cytologic screening per year or more often if recommended by a *physician*;
5. Screening mammography for all *members* over 35, baseline mammogram for *members* 35 to 39 years of age and annual mammogram for *members* 40 years of age and older, for *members* under 40 with a family history of breast cancer or other risk factors mammograms are covered at an age and interval considered *medically necessary*, a comprehensive ultrasound screening of an entire breast or breasts when a mammogram demonstrates medical necessity as described, a screening MRI when *medically necessary*, as determined by a *physician*, and a *breast tomosynthesis*;
6. Breast cancer chemoprevention counseling for *members* at higher risk;

7. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing *members*;
8. Cervical cancer screening for sexually active *members*;
9. Chlamydia infection screening for younger *members* and other *members* at higher risk;
10. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling;
11. Domestic and interpersonal violence screening and counseling for all *members*;
12. Folic Acid supplements for *members* who may become pregnant;
13. Gestational diabetes mellitus screening. The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation;
14. Gonorrhea screening for all *members* at higher risk;
15. Hepatitis B screening for pregnant *members* at their first prenatal visit;
16. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active *members*;
17. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for *members* with normal cytology results who are 30 or older;
18. Coverage for *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis;
19. Pre-eclampsia prevention;
20. Rh Incompatibility screening for all pregnant *members* and follow-up testing for *members* at higher risk;
21. *Tobacco or nicotine use* screening and interventions for all *members*, and expanded counseling for pregnant tobacco users;
22. Sexually Transmitted Infections (STI) counseling for sexually active *members*;
23. Syphilis screening for all pregnant *members* or other *members* at increased risk; and
24. Well-woman visits to obtain recommended preventive services.

Covered Preventive Services for Children including:

1. Alcohol and drug use assessments for adolescents;
2. Anticipatory Guidance: annually three years and older; more often if under three years;
3. Autism screening for children at 18 and 24 months;
4. Behavioral assessments for children through age 21;
5. Blood Pressure screening for children through age 21;
6. Cervical dysplasia screening for sexually active *members*;
7. Congenital hypothyroidism screening for newborns;
8. Depression screening for adolescents;
9. Developmental screening for children under age three, and surveillance throughout childhood;
10. Dyslipidemia screening for children at higher risk of lipid disorders through age 21;
11. Fluoride chemoprevention supplements for children between six months and five years regardless of water source;
12. Gonorrhea preventive medication for the eyes of all newborns;
13. Hearing screening;
14. Height, weight and body mass index measurements for children through age 21;
15. Hematocrit or hemoglobin screening for children;
16. Hemoglobinopathies or sickle cell screening for newborns;
17. Hepatitis B screening: non-pregnant adolescents. The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection;
18. HIV screening for adolescents at higher risk;
19. Hypothyroid screening;
20. Immunization vaccines for children from birth to age 21—doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis;
    - Haemophilus influenzae type b;
    - Hepatitis A;

- Hepatitis B;
- Human Papillomavirus;
- Inactivated Poliovirus;
- Influenza (Flu Shot);
- Measles, Mumps, Rubella;
- Meningococcal;
- Pneumococcal;
- Rotavirus;
- Varicella.

21. Intimate partner violence screening: women of childbearing age. The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse;
22. Iron supplements for children ages 6 to 12 months at risk for anemia;
23. Lead screening;
24. Medical history for all children throughout development through age 21;
25. Newborn blood screening;
26. Obesity screening and counseling;
27. Oral health risk assessment for children;
28. Phenylketonuria (PKU) screening for this genetic disorder in newborns;
29. Physical Examination Procedures: critical congenital heart defect screening newborn;
30. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
31. Skin cancer behavioral counseling. The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer;
32. *Tobacco or nicotine use* interventions: children and adolescents. The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of *tobacco or nicotine use* in school-aged children and adolescents;
33. Tuberculin testing for children at higher risk of tuberculosis through age 21;
34. Vision screening for all children; and
35. Whole body skin examination for the detection of skin cancer.

Benefits for preventive health services listed in this provision are exempt from any *deductibles, coinsurance amounts*, and *copayment amounts* under the *contract* when the services are provided by a *network provider.* Whether something is preventive is determined by the claim service data submitted by the provider.

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

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

Notification

As required by PHS Act section 2715(d)(4), we will provide 60 days advance notice to you before any material modification will become effective, including any changes to preventive benefits covered under this *contract*.

You may access our website or the Member Services Department at 1-855-745-5507 (TTY 1-844-517-3431) to get the answers to many of your frequently asked questions regarding preventive services. Our website has resources and features that make it easy to get quality care. Our website can be accessed at AmbetterofIllinois.com.

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

Covered Services for Maternity Care:
An *inpatient* stay is covered for mother and newborn for a minimum of 48 hours following a vaginal delivery and 96 hours following a delivery by cesarean section. We do not require that a *physician* or other health care provider obtain *prior authorization* for the delivery. An *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require notification to the health plan.

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

1. *Outpatient* and *inpatient* pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, and childbirth classes.
2. *Physician* home visits and office services.
3. Pasteurized donated human breast milk, which may include human milk fortifiers, if indicated by a prescribing licensed *medical practitioner* and other conditions of *prior authorization* are met.
4. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
5. *Complications of pregnancy*.
6. *Hospital* stays for other *medically necessary* reasons associated with maternity care.
7. Coverage for abortion care, including abortifacient drugs.
8. 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* expenses for maternity care. This provision also does not require a *member* who is eligible for coverage under a health benefit plan to:

(1) give birth in a *hospital* or other health care facility; or
(2) remain under *inpatient* care in a *hospital* or other health care facility for any fixed term following the birth of a child.

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

Duty to Cooperate: We do not cover services or supplies related to a *member's pregnancy* when a *member* is acting as a *surrogate* and has entered into a *surrogacy arrangement*. For more information on excluded services, please see the General Non-Covered Services and Exclusions section. *Members* who are a *surrogate* at the time of enrollment or *members* who agree to a *surrogacy arrangement* during the plan year must, within 30 days of enrollment or agreement to participate in a *surrogacy arrangement*, send us written notice of the *surrogacy arrangement* to Ambetter of Illinois at the Member Services Department, 200 East Randolph St. Chicago, IL 60601. 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.

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).

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

Transplant Expense Benefits
Covered services for transplant service expenses:
Transplants are a *covered service* when a *member* is accepted as a transplant candidate and obtains *prior authorization* in accordance with this *contract*. *Prior authorization* must be obtained through the *"Center of Excellence"* before an evaluation for transplant. We may require additional information such as testing and/or treatment before determining *medical necessity* for the transplant benefit. *Authorization* must be obtained prior to performing any related services to the transplant *surgery*. Transplant services must meet medical criteria as set by Medical Management Policy (as found on our website at www.ambetterofillinois.com).

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 *member'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 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 a *medically necessary* transplant, live donation, *covered service expenses* will be provided for:

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

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 transplant from any *physician*. However, if a transplant is performed in a *Center of Excellence*:

1. We will pay for the following services when the *member* is required to travel more than 50 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 an *immediate family* member to accompany the *member* to and from the *Center of Excellence*, in the United States. If the recipient is an *eligible child*, we will cover transportation for two *immediate family* members to accompany the child.
    b. When the *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 reimburse *members* for the proof of costs directly related for transportation, lodging and any of the following approved items listed in the *member* transplant reimbursement guidelines. However, you must make the arrangements and provide the necessary paid receipts for reimbursement within 6 months of the date of service in order to be reimbursed.
    e. Incurred costs related to a certified/registered service animal for the transplant *member* and/or donor.

Please refer to the *member* resources page for *member* reimbursement transplant travel forms and information at AmbetterofIllinois.com.

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these transplant expense benefits:

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.
2. For animal to human transplants.
3. To keep a donor alive for the transplant operation, except when *authorized* through the *Center of Excellence*.
4. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision 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 FDA regulation, regardless of whether the trial is subject to FDA oversight.
8. The acquisition cost for the organ or bone marrow, when provided at an unauthorized facility or not obtained through the *Center of Excellence*.
9. For any transplant services and/or travel related expenses for the *member* and donor, when performed outside of the United States.
10. The following ancillary items listed below, will not be subject to *member* reimbursement under this *contract*:
    a. Alcohol/tobacco
    b. Car rental (unless pre-approved by Case Management)

c. Vehicle maintenance for motorized, hybrid, and electric cars (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 or 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 this *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.

Note: When a prescribing *physician* has indicated on a prescription "may not substitute", following a human organ transplant, we will not require, or cause a pharmacist to substitute another immunosuppressant drug, without notification and the documented consent of the prescribing *physician* and the patient.

PRIOR AUTHORIZATION

Ambetter of Illinois insured by Celtic Insurance Company 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.
2. Concurrent review – occurs when a medical service is reviewed as it happens (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 health covered service expenses* require *prior authorization*. In general, *network providers* must obtain *authorization* from us prior to providing a service or supply to a *member.* However, there are some *network eligible expenses* for which you must obtain the *prior authorization*.

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

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

Prior authorization requests (medical and *behavioral health*) must be received by telephone, 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*, or *hospice* facility.
2. At least 30 days prior to the initial evaluation for organ transplant services.
3. At least 30 days prior to receiving clinical trial services.
4. Within 24 hours of any *inpatient* admission, including emergent *inpatient* admissions.
5. At least 5 days prior to the start of *home health care* except those *members* needing *home health care* after *hospital* discharge.

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

1. For urgent concurrent reviews, within 24 hours of receipt of the request.
2. For urgent pre-service reviews, within 48 hours from date of receipt of request.
3. For non-urgent pre-service reviews, within 5 days of receipt of the request.
4. For post-service or retrospective reviews, within 30 calendar days of receipt of the request.

If your *prior authorization* request has been denied, please refer to the Internal Grievance, Appeals, and External Review Procedures section of this *contract* for information on your right to *appeal* a denied *authorization*.

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. There is a penalty if treatment is not *authorized* prior to service. The penalty is a 20 percent reduction of the *eligible expenses* for all charges related to the treatment, not to exceed $1,000. The penalty applies to all otherwise *eligible expenses* that are:

1. Incurred for treatment without *prior authorization*;

2. Incurred during additional *hospital* days without *prior authorization*; or
3. Determined to be inappropriately *authorized* following a retrospective review, or inappropriately *authorized* due to intentional misrepresentation of facts or false statements.

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.*

If we *authorize* a proposed admission, treatment, or *covered service expense* by a *network provider* based upon the complete and accurate submission of all necessary information relative to an eligible *member*, we shall not retroactively deny this *authorization* if the *network provider* renders the *covered service expense* in good faith and pursuant to the *authorization* and all of the terms and conditions of the *network provider's contract* with us.

Transition of Services
We shall notify new *members* and current *members* of the availability of transitional services for conditions that require ongoing course of treatment.

New *members* must request the option of transitional services in writing, within 15 days after receiving notification of the availability of transitional services.

Members whose *physician* leaves the *network* of health care providers shall request the option of transitional services in writing within 30 days after receipt of notification of termination of the *physician*.

Within 15 days after receiving such notification from the *member*, we shall notify the *member* if a denial is issued for the *member's* request of transitional services based on the *member's physician* refusing to agree to accept our plan's reimbursement rates, adhere to our plan's quality assurance requirements, provide our plan with necessary medical information related to the *member's* care, or otherwise adhere to our plan's policies and procedures. The notification shall be in writing and include the specific reason for such denial.

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 *PCP* must request *prior authorization* from us before you receive services from a *non-network provider*. Otherwise, you will be responsible for all charges incurred.

If you receive emergent services from a *non-network provider*, you are responsible for an amount equal to your responsibility for similar services provided by a *network provider*. If you believe you have been billed in error, please contact Member Services at 1-855-745-5507 (TTY 1-844-517-3431).

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *member* in the absence of insurance covering the charge.
2. Expenses, fees, taxes or surcharges imposed on the *member* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.
3. Any services performed by a *member* of 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. 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;* 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*.
2. For any portion of the charges that are in excess of the *eligible expense.*
3. For cosmetic breast reduction or augmentation, except for the *medically necessary* treatment of gender dysphoria.
4. For the reversal of sterilization and reversal of vasectomies.
5. For expenses for television, telephone, or expenses for other persons.
6. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
7. For telephone consultations between providers, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
8. For stand-by availability of a *medical practitioner* when no treatment is rendered.
9. For *dental service expenses,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Medical Service Benefits.
10. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect.
11. For Mental health exams and services involving:
    a. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
    b. Pre-marital counseling;
    c. Court-ordered care or testing, or required as a condition of parole or probation. Benefits will be allowed for services that are *medically necessary* and would otherwise be covered under this *contract*;
    d. Testing of aptitude, ability, intelligence or interest; and
    e. Evaluation for the purpose of maintaining employment. Benefits will be allowed for services that would otherwise be covered under this *contract.*
12. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
13. While confined primarily to receive *custodial care* or nursing services (unless expressly provided for in this *contract)*.

14. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*. Coverage for eyeglasses is listed under Outpatient Medical Supplies Expense Benefits, Pediatric Vision Expense Benefits, and Vision Expense Benefits.
15. 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.
16. For treatment received outside the United States, except for a medical *emergency*.
17. For fetal reduction *surgery*.
18. Except as specifically identified as a *covered service expense* under the *contract*, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
19. 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.
20. For the following miscellaneous items: artificial insemination (except where required by federal or state law); 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-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *rehabilitation services* for the enhancement of job, athletic or recreational performance; routine or elective care outside the *service area*; transportation expenses, unless specifically described in this *contract*.
21. For any non-*medically necessary* court ordered care for a medical/surgical or mental health/*substance use disorder* diagnosis, unless required by state law.
22. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a *member's* own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
23. Services or care provided or billed by a school, *custodial care* center for the developmentally disabled.
24. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
25. Biofeedback.
26. 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.
27. For any medicinal and recreational use of cannabis or marijuana.
28. Immunizations that are not *medically necessary* or medically indicated. This includes those used for travel and occupational purposes.
29. For expenses, services, and treatments from a massage therapist to touch and manipulate the muscles and other soft tissues of the body.
30. 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.
31. For expenses, services, and treatments from a naturopathic specialist for treatment or prevention, self-healing and use of natural therapies.
32. For expenses, services, and treatments related to private duty nursing on an *inpatient* basis.
33. For expenses for services related to dry needling.
34. *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) Preimplantation genetic diagnosis relating to a *surrogacy arrangement*;
f) Any complications of the child or *surrogate* resulting from the *pregnancy*;
g) Any other health care services, supplies and medication relating to a *surrogacy arrangement;* or

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.

Exceptions to Limitations:

1. This *contract* will not deny *medically necessary* breast implant removal for an *illness* or *injury.* However, this exception will not apply to the removal of breast implants that were done solely for cosmetic purposes.
2. This *contract* will not deny or exclude coverage for fibrocystic breast condition in the absence of a breast biopsy demonstrating an increased disposition to the development of breast cancer unless the *covered person's* medical history is able to confirm a chronic, relapsing, symptomatic breast condition.

TERMINATION

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

1. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *contract* (including, but not limited to, the Grace Period provision) or the date that we have not received timely premium payments in accordance with the terms of this *contract*;
2. The date of termination that the Health Insurance Marketplace provides us upon your request of cancelation;
3. For a dependent child reaching the limiting age of 26, coverage under this *contract*, for a dependent child, will terminate at 11:59 p.m. on the last day of the year in which the dependent child reaches the limiting age of 26;
4. The date we decline to renew this *contract*, as stated in the discontinuance provision of this *contract*;
5. The date of your death, if this *contract* is an individual plan;
6. The date a *member's* eligibility for coverage under this *contract* ceases as determined by the Health Insurance Marketplace; or
7. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or

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

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

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

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

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

Reinstatement shall not change any provisions of the *contract.*

SUBROGATION

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

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

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

As a condition for our payment, the *covered person* or anyone acting on the *covered person's* behalf including, but not limited to, the guardian, legal representatives, estate, or heirs agrees:

1. To fully cooperate with us in order to obtain information about the *loss* and its cause;
2. To immediately inform us in writing of any claim made or lawsuit filed on behalf of a *covered person* in connection with the *loss*;
3. To include the amount of benefits paid by us on behalf of a *covered person* in any claim made against any *third party*;
4. To give Ambetter of Illinois a first-priority lien on any recovery, settlement or judgment or other sources of compensation which may be had from any party to the extent of the full cost of all benefits associated with *third party injuries* provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
5. To pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due Ambetter of Illinois as reimbursement for the full cost of all benefits associated with *third party injuries* provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement);
6. That we:
    a. Will have a lien on all money received by a *covered person* in connection with the *loss* equal to the amount we have paid;
    b. May give notice of that lien to any *third party* or *third party's* agent or representative;
    c. Will have the right to intervene in any suit or legal action to protect our rights;
    d. Are subrogated to all of the rights of the *covered person* against any *third party* to the extent of the benefits paid on the *covered person's* behalf; and
    e. May assert that subrogation right independently of the *covered person*;
7. To take no action that prejudices our reimbursement and subrogation rights, including, but not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan;
8. To sign, date, and deliver to us any documents we request that protect our reimbursement and subrogation rights; and
9. To not settle any claim or lawsuit against a *third party* without providing us with written notice of the intent to do so.

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

CLAIMS

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

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

How to Submit a Claim
Network providers are contractually required to submit claims directly to us on your behalf for *covered services,* but sometimes you may need to submit claims yourself for *covered services*. This usually happens if:

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

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

To request reimbursement for a *covered service*, you need a copy of the detailed claim from your provider. You also need to submit a copy of the *member* reimbursement claim form posted at ambetterofillinois.com under "For Members – Forms and Materials". Send all the documentation to us at the following address:

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

In situations where *network providers* are contractually required to submit claims directly to us on your behalf for *covered services,* you will not receive from us an acknowledgement of the claim submission, notices and explanations for claim delays, or notice of recourse available through contacting the Illinois Department of Insurance.

Time for Payment of Claims
Benefits will be paid within 30 days after receipt of *proof of loss*. Should we determine that additional supporting documentation is required to establish responsibility of payment, we shall pay benefits within 30 days after receipt of *proof of loss*. If we do not pay within such period, we shall pay interest at the rate of nine percent per annum from the 30th day after receipt of such *proof of loss* to the date of late payment.

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

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

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

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 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 AmbetterofIllinois.com.

The amount of reimbursement will be based on the following:

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

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

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

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

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

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

Upon request by the custodial parent, we will:

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

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

Physical Examination
We 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.

Post Stabilization Services
Timely determination shall mean a determination is made within 30 days after we receive a claim for post stabilization services if no additional information is needed to determine that services rendered were not contrary to our instructions. In the event additional information is necessary to make such a determination, we shall request the medical record documenting the time, phone number dialed, and the result of the communication for request for *authorization* of post stabilization medical services as well as the post stabilization medical services rendered within 15 days after receipt of the post stabilization services claim and make a determination within 30 days after its receipt.

Reimbursement for covered post-stabilization procedures shall be provided if we approve authorization for the services rendered. Reimbursement shall also be provided if, after two documented good faith efforts, the provider has attempted to contact us for *prior authorization* of post stabilization medical services, and we were not accessible or did not deny the authorization within 60 minutes of the request. As used in this section, "two documented good faith efforts" means the health care provider has called the telephone number on the enrollee's health insurance card or other available number either 2 times or one time and an additional call to any referral number provided and "good faith" means honesty of purpose, freedom from intention to defraud, and being faithful to one's duty or obligation.

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

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

Grievance Process
A *grievance* or *complaint* is an expression of dissatisfaction regarding our products or services. You or your *authorized representative* may submit a *grievance* verbally or in writing. Depending on the nature of the *grievance* and whether or not a response is requested, we will respond verbally and/or in writing within 60 business days following receipt of the *grievance*, or should a *member's* medical condition necessitate an expedited review a response within 24 hours. We may extend the response time for up to an additional 30 days in the event additional information is required.

The response will state the reason for our decision, and inform the *member* of the right to pursue a further review, and explain the procedures for initiating such review. *Grievances* will be considered when measuring the quality and effectiveness of our products and services.

Coordination of Benefits with a Medicare plan
If a *member* and/or *dependent member* is enrolled in Medicare and Ambetter of Illinois insured by Celtic Insurance Company, Medicare will be the primary payer and Ambetter of Illinois insured by Celtic Insurance Company will be the secondary payer. Ambetter of Illinois insured by Celtic Insurance Company will not pay benefits until after Medicare has paid its share of the costs. Ambetter of Illinois insured by Celtic Insurance Company will reimburse part or all of the allowable expense left unpaid. The *member* will be responsible for the remaining out-of-pocket expenses as applicable.

A *member* or *dependent member* enrolled in Ambetter of Illinois insured by Celtic Insurance Company and Medicare is required to notify the Health Insurance Marketplace. The *member*'s profile will be updated to indicate the *member* has Medicare coverage. *Members* may no longer be eligible to receive a premium subsidy for the Health Insurance Marketplace plan once Medicare coverage becomes effective.

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

No Third Party Beneficiaries
This *contract* is not intended to, nor does it, create or grant any rights in favor of any *third party*, including but not limited to any *hospital,* provider or *medical practitioner* providing services to you, and this *contract* shall not be construed to create any *third party* beneficiary rights.

INTERNAL GRIEVANCE, APPEALS, AND EXTERNAL REVIEW PROCEDURES

INTERNAL PROCEDURES

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

Call Member Services
Please contact our Member Services department at 1-855-745-5507 (TTY 1-844-517-3431) if you have questions or concerns with these procedures. We will attempt to answer your questions during initial contact, as most concerns can be resolved with one phone call.

Complaints, Grievances, & Appeals

Complaints
Basic elements of a *complaint* include:

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

Grievances
Grievances may be filed by:

1. A *member;*
2. A person authorized to act on behalf of the *member*.

Note: Written *authorization* is not required; however, if received, we will accept any written expression of *authorization* without requiring specific form, language, or format.

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

1. Provision of services;
2. Determination of a diagnosis or level of service required for evidence-based treatment of *autism spectrum disorders*; and
3. Claims practices.
4. Is unable to give consent: a *spouse*, family *member*, or the treating provider; or

5. In the event of an *expedited appeal*: the person for whom the insured has verbally given *authorization* to represent the *member*.

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

Appeals
Appeals may be filed by:
1. A *member*;
2. The *member's* provider; or
3. A person authorized to act on behalf of the *member*.

A *member* has a right to a file a *grievance* and/or *appeal* review. *Members* have the right to submit written comments, documents, records, and other information relating to the claim for benefits. An *adverse benefit determination* must be *appealed* within 180 days. *Member*s have the right to review the claim file and to present evidence and testimony as part of the internal review process. The *grievance* and/or *appeal* should be sent to the following address:

Ambetter of Illinois
Attn.: Appeals and Grievances
P.O. Box 10341
Van Nuys, CA 91410
Phone # 1-855-745-5507
TTY 1-844-517-3431
Fax # 1-833-886-7956

A *member* has the right to request an internal review in tandem with a provider's request for an expedited internal review or a concurrent review is in process.

Grievances will be promptly investigated. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of an *appeal*.

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

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

Resolution Timeframes
1. *Grievances* regarding quality of care, quality of service, or reformation will be resolved within 30 calendar days of receipt. The time period may be extended for an additional 30 calendar days, making the maximum time for the entire *grievance* process 60 calendar days if we provide the *member* and the

member's authorized representative, if applicable, written notification of the following within the first 30 calendar days:
    a. That we have not resolved the *grievance*;
    b. When our resolution of the *grievance* may be expected; and
    c. The reason why the additional time is needed.
2. *Appeals* regarding *adverse benefit determinations* will be resolved within 15 business days The party who filed the *appeal* shall be notified within three business days of all information required to evaluate the *appeal*, and once provided, we will notify the *member, party filing appeal, and the member's PCP* in writing of the *appeal* decision. The time period to resolve the *appeal* may be extended for an additional 15 calendar days, if we provide the *member* and the *member's authorized representative*, if applicable, written notification of the following within the first 15 business days:
    a. That we have not resolved the *appeal*;
    b. When our resolution of the *appeal* may be expected; and
    c. The reason why the additional time is needed.

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

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

Grievance Committee

Within ten days of receipt of the initial internal *grievance* resolution letter, the *member* has the right to request a *Grievance Committee* hearing if they do not agree with the decision. The *Grievance Committee* membership will consist of 50 percent active member membership and will conduct the hearing within 2 weeks (or 14 days) from the receipt of request. The *Grievance Committee* shall meet at our main office, or other office designated by us if the main office is not within 50 miles of the *member's* home address, if the *member* wishes to attend in person. The *Grievance Committee* may also meet virtually, if more convenient for the *member*. The *Grievance Committee* coordinator will work with a *member* to determine a mutually agreed upon date and time for the panel hearing. The *member* shall have the right to attend and participate in the formal *grievance* proceedings, and the right to be represented by a designated representative of his or her choice.

The *member* has the right to review the information, as outlined in the *member's* rights, that was used to make the initial determination and has the right to supply any additional information which the *member* would like the *Grievance Committee* to review as part of their final and binding decision. A written decision from the *Grievance Committee* shall be provided within 60 days from receipt of the original *grievance*. The determination by the *Grievance Committee* may be extended for a period not to exceed 30 days in the event of a delay in obtaining the documents or records necessary for the resolution of the *grievance*.

Expedited Appeal

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

An *expedited appeal* shall be resolved as expeditiously as the *member*'s health condition requires but not more than 24 hours after receipt of the *grievance*.

Due to the 24-hour resolution timeframe, the standard requirements for notification, *grievance* panel, and acknowledgement do not apply. The provider who recommended the service and/or the *member's PCP*, along with the *member*, shall be notified orally of the decision followed-up by a written notice of the determination.

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

Written Grievance and Appeal Responses
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 to the grievant/appellant must include (if applicable):

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 voting *member* of the *Grievance Committee*; and
4. A written description of position titles of panel *member*s involved in making the decision.
5. If upheld or partially upheld, it is also necessary to include (if applicable):
    a. A clear explanation of the decision;
    b. Reference to the specific plan provision on which the determination is based;
    c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *member's* claim for benefits.
    d. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
    e. If the *adverse benefit determination* is based on a medical necessity or *experimental* treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant 's medical circumstances, or a statement that such explanation will be provided free of charge upon request.;
    f. Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse benefit determination*;
    g. The date of service;
    h. The health care provider's name;
    i. The claim amount;
    j. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
    k. The health plan's denial code with corresponding meaning;
    l. A description of any standard used, if any, in denying the claim;
    m. A description of the external review procedures, if applicable;
    n. The right to bring a civil action under state or federal law;
    o. A copy of the form that authorizes the health plan to disclose protected health information, if applicable;
    p. That assistance is available by contacting the specific state's consumer assistance department, if applicable; and
    q. A culturally linguistic statement based upon the *member's* county or state of *residence* that provides for oral translation of the *adverse benefit determination*, if applicable.

Complaints received from the State Insurance Department
The commissioner may require us to treat and process any *complaint* received by the State Insurance Department by, or on behalf of, a *member* as a *grievance* as appropriate. We will process the State Insurance Department *complaint* when the commissioner provides us with a written description of the *complaint*. Ambetter of Illinois must respond to Insurance Department *complaints* within 21 days from receipt.

Complaints filed directly with the Illinois Department of Insurance should be sent to the following:

Office of Consumer Health Insurance
320 W. Washington Street
Springfield, IL 62767
Toll-free Phone No. 1-877-527-9431
Facsimile No. 1-217-558-2083
DOI.complaints@illinois.gov
https://insurance.illinois.gov/Complaints/UnderstandComplaintProcess.html

External Review
An external review decision is binding on us. An external review decision is binding on the *member* except to the extent the claimant has other remedies available under applicable federal or state law. We will pay for the costs of the external review performed by the independent reviewer.

If we have denied your request for the provision of or payment for a health care service or course of treatment, you have the right to have our decision reviewed by an independent review organization not associated with us.

Applicability/Eligibility
External review is available for *grievances* that involve:

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

After exhausting the internal review process, the *member* has four months to make a written request to the *Grievance* Administrator for external review after the date of receipt of our internal response.

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

External Review Process
Request for External Review
A *member* or the *member's authorized representative* may make a request for a standard external or expedited external review of an adverse determination or final adverse determination. Any pertinent additional information may be submitted with the request for standard or expedited external review.

Exhaustion of Internal Appeal Process
For urgent situations, a *member* shall skip the internal *appeal* and standard review process and request an expedited external review.

A request for an external review shall not be made until the *member* has exhausted our internal *appeal* process. A *member* shall be considered to have exhausted our internal *appeal* process if:

1. the *member* or the *member's authorized representative* has filed an *appeal* under our internal *appeal* process and has not received a written decision on the *appeal* 15 business days following the date the *member* or the *member 's authorized representative* files an *appeal* of an adverse determination that involves a concurrent or prospective review request or 15 business days following the date the *member* or the *member's authorized representative* files an *appeal* of an adverse determination that involves a retrospective review request, except to the extent the *member* or the *member's authorized representative* requested or agreed to a delay;
2. the *member* or the *member*'s *authorized representative* filed a request for an *expedited appeal* of an adverse determination and has not received a decision on such request from us within 48 hours, except to the extent the *member* or the *member's authorized representative* requested or agreed to a delay;
3. We agree to waive the exhaustion requirement;
4. the *member* has a medical condition in which the timeframe for completion of (A) an *expedited appeal* involving an adverse determination, (B) a final adverse determination, or (C) a standard external review would seriously jeopardize the life or health of the *member* or would jeopardize the *member's* ability to regain maximum function;
5. an adverse determination concerns a denial of coverage based on a determination that the recommended or requested health care service or treatment is *experimental* or *investigational* and the *member's* health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated; in such cases, the *member* or the *member's authorized representative* may request an expedited external review at the same time the *member* or the *member's authorized representative* files a request for an expedited internal *appeal* involving an adverse determination; the independent review organization assigned to conduct the expedited external review shall determine whether the *member* is required to complete the expedited review of the *appeal* prior to conducting the expedited external review; or
6. We have failed to comply with applicable State and federal law governing internal claims and *appeals* procedures.

Standard External Review
Within four months after the date of receipt of a notice of an adverse determination or final adverse determination, a *member* or the *member's authorized representative* may file a request for an external review with the Director. Within one business day after the date of receipt of a request for external review, the Director shall send a copy of the request to us. The addresses for the Director of Insurance follow:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 W. Washington Street
Springfield, IL 62767
(877) 850-4740 Toll-free phone
(217) 557-8495 Fax number

Within five business days following the date of receipt of the external review request, we shall complete a preliminary review of the request to determine whether:

1. the individual is or was a *member* at the time the health care service was requested or at the time the health care service was provided;
2. the health care service that is the subject of the adverse determination or the final adverse determination is a *covered service* under the *member's* health benefit plan, but we have determined that the health care service is not covered;
3. the *member* has exhausted our internal *appeal* process unless the *member* is not required to exhaust our internal *appeal* process pursuant to this act; and
4. the *member* has provided all the information and forms required to process an external review, as specified in this act.

If the request:

1. is not complete, we shall inform the Director and *member* and, if applicable, the *member's authorized representative* in writing and include in the notice what information or materials are required by this Act to make the request complete; or
2. is not eligible for external review, we shall inform the Director and *member* and, if applicable, the *member's authorized representative* in writing and include in the notice the reasons for its ineligibility.

The notice of initial determination of ineligibility shall include a statement informing the *member* and, if applicable, the *member's authorized representative* that our initial determination that the external review request is ineligible for review may be objected to the Director by filing a *complaint* with the Illinois Department of Insurance.

Notwithstanding our initial determination that the request is ineligible for external review, the Director may determine that a request is eligible for external review and require that it be referred for external review. Whenever the Director receives notice that a request is eligible for external review following the preliminary review conducted, within one business day after the date of receipt of the notice, the Director shall:

1. assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Director and notify us of the name of the assigned independent review organization; and
2. notify in writing the *member* and, if applicable, the *member's authorized representative* of the request's eligibility and acceptance for external review and the name of the independent review organization.

The Director shall include in the notice provided to the *member* and, if applicable, the *member's authorized representative* a statement that the *member* or the *member's authorized representative* may, within five business days following the date of receipt of the notice provided, submit in writing to the assigned independent review organization additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five business days.

The assignment by the Director of an approved independent review organization to conduct an external review shall be done on a random basis among those independent review organizations approved by the Director.

Within five business days after the date of receipt of the notice provided, we or our designee *utilization review* organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination; in such cases, the following provisions shall apply:

1. Except as provided, failure by us or our *utilization review* organization to provide the documents and information within the specified time frame shall not delay the conduct of the external review.

2. If we or our *utilization review* organization fails to provide the documents and information within the specified time frame, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.
3. Within one business day after making the decision to terminate the external review and make a decision to reverse the adverse determination or final adverse determination, the independent review organization shall notify the Director, us, the *member* and, if applicable, the *member's authorized representative*, of its decision to reverse the adverse determination.

Upon receipt of the information from us or our *utilization review* organization, the assigned independent review organization shall review all of the information and documents and any other information submitted in writing to the independent review organization by the *member* and the *member's authorized representative*.

Upon receipt of any information submitted by the *member* or the *member's authorized representative*, the independent review organization shall forward the information to us within one business day.

Upon receipt of the information, if any, we may reconsider its adverse determination or final adverse determination that is the subject of the external review.

Reconsideration by us of our adverse determination or final adverse determination shall not delay or terminate the external review.

The external review may only be terminated if we decide, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination. In such cases, the following provisions shall apply:

1. Within one business day after making the decision to reverse its adverse determination or final adverse determination, we shall notify the Director, the *member* and, if applicable, the *member's authorized representative*, and the assigned independent review organization in writing of its decision.
2. Upon notice from us that we have made a decision to reverse its adverse determination or final adverse determination, the assigned independent review organization shall terminate the external review.

In addition to the documents and information provided by us or our *utilization review* organization and the *member* and the *member's authorized representative*, if any, the independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

1. the *member's* pertinent medical records;
2. the *covered person's* health care provider's recommendation;
3. consulting reports from appropriate health care providers and other documents submitted by us or our designee *utilization review* organization, the *member*, the *member's authorized representative*, or the *covered person's* treating provider;
4. the terms of coverage under the *member's* health benefit plan with us to ensure that the independent review organization's decision is not contrary to the terms of coverage under the *member's* health benefit plan with the health carrier, unless the terms are inconsistent with applicable law;
5. the most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
6. any applicable clinical review criteria developed and used by us or our designee *utilization review* organization;
7. the opinion of the independent review organization's clinical reviewer or reviewers after considering the above items to the extent the information or documents are available and the clinical reviewer or reviewers considers the information or documents appropriate; and

8. in the case of *medically necessary* determinations for *substance use disorders*, the patient placement criteria established by the American Society of Addiction Medicine.

Within 5 days after the date of receipt of all necessary information, but in no event more than 45 days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the Director, us, the *member*, and, if applicable, the *member's authorized representative*. In reaching a decision, the assigned independent review organization is not bound by any claim determinations reached prior to the submission of information to the independent review organization. In such cases, the following provisions shall apply:

The independent review organization shall include in the notice:
1. a general description of the reason for the request for external review;
2. the date the independent review organization received the assignment from the Director to conduct the external review;
3. the time period during which the external review was conducted;
4. references to the evidence or documentation, including the evidence-based standards, considered in reaching its decision;
5. the date of its decision;
6. the principal reason or reasons for its decision, including what applicable, if any, evidence-based standards that were a basis for its decision; and
7. the rationale for its decision.

Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, we immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

Expedited External Review
A *member* or a *member's authorized representative* may file a request for an expedited external review with the Director either orally or in writing:
1. immediately after the date of receipt of a notice of serious jeopardization of *member's* ability to regain maximum function, prior to a final adverse determination;
2. immediately after the date of receipt of a notice of final adverse determination; or
3. if we fail to provide a decision on request for an *expedited appeal* within 48, except to the extent the *member* or *authorized representative* requested or agreed to a delay.

Upon receipt of a request for an expedited external review, the Director shall immediately send a copy of the request to us. Immediately upon receipt of the request for an expedited external review we shall determine whether the request meets the reviewability requirements. In such cases, the following provisions shall apply:
1. We shall immediately notify the Director, the *member's*, and, if applicable, the *member's authorized representative* of its eligibility determination.
2. The notice of initial determination shall include a statement informing the *member's* and, if applicable, the *member's authorized representative* that a health carrier's initial determination that an external review request is ineligible for review may be objected to the Director by filing a *complaint* with the Illinois Department of Insurance.
3. The Director may determine that a request is eligible for expedited external review notwithstanding our initial determination that the request is ineligible and require that it be referred for external review.
4. In making a determination, the Director's decision shall be made in accordance with the terms of the *covered person's* health benefit plan, unless such terms are inconsistent with applicable law, and shall be subject to all applicable provisions of this provision.
5. The Director may specify the form for our notice of initial determination and any supporting information to be included in the notice.

Upon receipt of the notice that the request meets the reviewability requirements, the Director shall immediately assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Director to conduct the expedited review. In such cases, the following provisions shall apply:

1. Assignment of an approved independent review organization to conduct an external review in accordance with this Section shall be made from those approved independent review organizations qualified to conduct external review as required by Sections 50 and 55 of the Health Carrier External Review Act.
2. The Director shall immediately notify us of the name of the assigned independent review organization. Immediately upon receipt from the Director of the name of the independent review organization assigned to conduct the external review, but in no case more than 24 hours after receiving such notice, we or our designee *utilization review* organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.
3. If we or our *utilization review* organization fails to provide the documents and information within the specified timeframe, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.
4. Within one business day after making the decision to terminate the external review and make a decision to reverse the adverse determination or final adverse determination, the independent review organization shall notify the Director, us, the *member*, and, if applicable, the *member's authorized representative* of its decision to reverse the adverse determination or final adverse determination.

In addition to the documents and information provided by us or our *utilization review* organization and any documents and information provided by the *member* and the *member's authorized representative*, the independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider information in reaching a decision.

As expeditiously as the *member's* medical condition or circumstances requires, but in no event more than 72 hours after the date of receipt of the request for an expedited external review by the independent review organization, the assigned independent review organization shall:

1. make a decision to uphold or reverse the final adverse determination; and
2. notify the Director, us, the *member*, the *member's* health care provider, and, if applicable, the *member's authorized representative*, of the decision.

In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during our *utilization review* process or the health carrier's internal *appeal* process.

Upon receipt of notice of a decision reversing the adverse determination or final adverse determination, we shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

If the notice provided was not in writing, then within 48 hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the Director, we, the *member's*, and, if applicable, the *member's authorized representative* including the information as applicable.

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

The assignment by the Director of an approved independent review organization to conduct an external review in accordance with this Section shall be done on a random basis among those independent review organizations approved by the Director.

External Review of Experimental or Investigational Treatment Adverse Determinations
Within four months after the date of receipt of a notice of an adverse determination or final adverse determination that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is *experimental* or *investigational*, a *member* or the *member's authorized representative* may file a request for an external review with the Director.

The following provisions apply to cases concerning expedited external reviews:

1. A *member* or the *member's authorized representative* may make an oral request for an expedited external review of the adverse determination or final adverse determination if the *covered person's* treating *physician* certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.
2. Upon receipt of a request for an expedited external review, the Director shall immediately notify the health carrier.
3. The following provisions apply concerning notice:
    a. Upon notice of the request for an expedited external review, the health carrier shall immediately determine whether the request meets the reviewability requirements. We shall immediately notify the Director and the *member* and, if applicable, the *member's authorized representative* of its eligibility determination.
    b. The Director may specify the form for our notice of initial determination and any supporting information to be included in the notice. The notice of initial determination under shall include a statement informing the *member* and, if applicable, the *member's authorized representative* of our initial determination that the external review request is ineligible for review may be objected to the Director by filing a *complaint* with the Illinois Department of Insurance.
4. The following provisions apply concerning the Director's determination:
    a. The Director may determine that a request is eligible for external review notwithstanding our initial determination that the request is ineligible and require that it be referred for external review.
    b. In making a determination, the Director's decision shall be made in accordance with the terms of the *member's* health benefit plan, unless such terms are inconsistent with applicable law.
5. Upon receipt of the notice that the expedited external review request meets the reviewability requirements, the Director shall immediately assign an independent review organization to review the expedited request from the list of approved independent review organizations compiled and maintained by the Director and notify us of the name of the assigned independent review organization.
6. At the time we receive the notice of the assigned independent review organization, we or our designee *utilization review* organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

Except for a request for an expedited external review, within one business day after the date of receipt of a request for external review, the Director shall send a copy of the request to us.

Within five business days following the date of receipt of the external review request, we shall complete a preliminary review of the request to determine whether:

1. the individual is or was a *member* in the health benefit plan at the time the health care service was recommended or requested or, in the case of a retrospective review, at the time the health care service was provided;
2. the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination is a *covered service* under the *member's* health benefit plan except for the health carrier's determination that the service or treatment is *experimental* or *investigational* for a particular medical condition and is not explicitly listed as an excluded benefit under the *member's* health benefit plan with us;

3. the *member's* health care provider has certified that one of the following situations is applicable:
    a. standard health care services or treatments have not been effective in improving the condition of the *member*;
    b. standard health care services or treatments are not medically appropriate for the *member's*; or
    c. there is no available standard health care service or treatment covered by us that is more beneficial than the recommended or requested health care service or treatment.
4. the *member's* health care provider:
    a. has recommended a health care service or treatment that the *physician* certifies, in writing, is likely to be more beneficial to the *member*, in the *physician*'s opinion, than any available standard health care services or treatments; or
    b. who is a licensed, board certified or board eligible *physician* qualified to practice in the area of medicine appropriate to treat the *member's* condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the *member* that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the *member* than any available standard health care services or treatments;
5. the *member* has exhausted our internal *appeal* process, unless the *member* is not required to exhaust the health carrier's internal *appeal*; and
6. the *member* has provided all the information and forms required to process an external review.

The following provisions apply concerning requests:

1. Within one business day after completion of the preliminary review, we shall notify the Director and *member* and, if applicable, the *member's authorized representative* in writing whether the request is complete and eligible for external review.
2. If the request:
    a. is not complete, then we shall inform the Director and the *member* and, if applicable, the *member's authorized representative* in writing and include in the notice what information or materials are required to make the request complete; or
    b. is not eligible for external review, then we shall inform the Director and the *member* and, if applicable, the *member's authorized representative* in writing and include in the notice the reasons for its ineligibility.
3. The Department may specify the form for our notice of initial determination and any supporting information to be included in the notice.
4. The notice of initial determination of ineligibility shall include a statement informing the *member* and, if applicable, the *member's authorized representative* that our initial determination that the external review request is ineligible for review may be objected to the Director by filing a *complaint* with the Illinois Department of Insurance.
5. Notwithstanding our initial determination that the request is ineligible for external review, the Director may determine that a request is eligible for external review and require that it be referred for external review.

Whenever a request for external review is determined eligible for external review, we shall notify the Director and the *member* and, if applicable, the *member's authorized representative*.

Whenever the Director receives notice that a request is eligible for external review following the preliminary review conducted, within one business day after the date of receipt of the notice, the Director shall:

1. assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Director and notify us of the name of the assigned independent review organization; and
2. notify in writing the *member* and, if applicable, the *member's authorized representative* of the request's eligibility and acceptance for external review and the name of the independent review organization.

The Director shall include in the notice provided to the *member* and, if applicable, the *member's authorized representative* a statement that the *member* or the *member's authorized representative* may, within five business days following the date of receipt of the notice provided, submit in writing to the assigned independent review organization additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five business days.

The following provisions apply concerning assignments and clinical reviews:

1. Within one business day after the receipt of the notice of assignment to conduct the external review, the assigned independent review organization shall select one or more clinical reviewers, as it determines is appropriate, to conduct the external review.
2. The provisions of this item apply concerning the selection of reviewers:
    a. In selecting clinical reviewers, the assigned independent review organization shall select *physicians* or other health care professionals who meet the minimum qualifications and, through clinical experience in the past three years, are experts in the treatment of the *member's* condition and knowledgeable about the recommended or requested health care service or treatment.
    b. Neither we*,* the *member,* nor the *member's authorized representative* will choose or control the choice of the *physicians* or other health care professionals to be selected to conduct the external review.

Each clinical reviewer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during our *utilization review* process or the health carrier's internal *appeal* process.

Within five business days after the date of receipt of the notice provided, we or our designee *utilization review* organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination; in such cases, the following provisions shall apply:

1. failure by us or our *utilization review* organization to provide the documents and information within the specified time frame shall not delay the conduct of the external review.
2. If *w*e or our *utilization review* organization fails to provide the documents and information within the specified time frame, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.
3. Immediately upon making the decision to terminate the external review and make a decision to reverse the adverse determination or final adverse determination, the independent review organization shall notify the Director, us, the *member*, and, if applicable, the *member's authorized representative* of its decision to reverse the adverse determination.

Upon receipt of the information from us or our *utilization review* organization, each clinical reviewer selected shall review all of the information and documents and any other information submitted in writing to the independent review organization by the *member* and the *member's authorized representative*.

Upon receipt of any information submitted by the *member* or the *member's authorized representative*, the independent review organization shall forward the information to us within one business day. In such cases, the following provisions shall apply:

1. Upon receipt of the information, if any, *w*e may reconsider its adverse determination or final adverse determination that is the subject of the external review.
2. Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review.
3. The external review may be terminated only if we decide, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for

the health care service that is the subject of the adverse determination or final adverse determination. In such cases, the following provisions shall apply:

a. Immediately upon making its decision to reverse its adverse determination or final adverse determination, we shall notify the Director, the *member* and, if applicable, the *member's authorized representative*, and the assigned independent review organization in writing of its decision.
b. Upon notice from the health carrier that we have made a decision to reverse its adverse determination or final adverse determination, the assigned independent review organization shall terminate the external review.

The following provisions apply concerning clinical review opinions:

1. Within 20 days after being selected, each clinical reviewer shall provide an opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.
2. Each clinical reviewer's opinion shall be in writing and include the following information:
    a. a description of the *member's* medical condition;
    b. a description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the *member* than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;
    c. a description and analysis of any medical or scientific evidence considered in reaching the opinion;
    d. a description and analysis of any evidence-based standard; and
    e. information on whether the reviewer's rationale for the opinion is based on 215 ILCS 180/42(m)(5).

The provisions concerning the timing of opinions related to expedited external review:

Each clinical reviewer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the *member's* medical condition or circumstances requires, but in no event more than five calendar days after being selected.

If the opinion provided was not in writing, then within 48 hours following the date the opinion was provided, the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required.

In addition to the documents and information provided by us or our *utilization review* organization and the *member* and the *member's authorized representative*, if any, each clinical reviewer selected, to the extent the information or documents are available and the clinical reviewer considers appropriate, shall consider the following in reaching a decision:

1. the *member's* pertinent medical records;
2. the *member's* health care provider's recommendation;
3. consulting reports from appropriate health care providers and other documents submitted by us or our designee *utilization review* organization, the *member*, the *member's authorized representative*, or the *member's* treating *physician* or health care professional;
4. the terms of coverage under the *member's* health benefit plan with us to ensure that, but for our determination that the recommended or requested health care service or treatment that is the subject of the opinion is *experimental* or *investigational*, the reviewer's opinion is not contrary to the terms of coverage under the *member's* health benefit plan with us and
5. whether the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition or medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested

health care service or treatment is more likely than not to be beneficial to the *member* than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

The following provisions apply concerning decisions, notices, and recommendations:

1. The provisions of this item apply concerning decisions and notices:
    a. Except as provided, within 20 days after the date it receives the opinion of each clinical reviewer, the assigned independent review organization, shall make a decision and provide written notice of the decision to the Director, us, the *member*, and the *member's authorized representative*, if applicable.
    b. For an expedited external review, within 48 hours after the date it receives the opinion of each clinical reviewer, the assigned independent review organization, shall make a decision and provide notice of the decision orally or in writing to the Director, us, the *member*, and the *member's authorized representative*, if applicable. If such notice is not in writing, within 48 hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the Director, us, the *member*, and the *member's authorized representative*, if applicable.

If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should be covered, then the independent review organization shall make a decision to reverse the health carrier's adverse determination or final adverse determination.

If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination or final adverse determination.

These provisions apply to cases in which the clinical reviewers are evenly split:

1. If the clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, then the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers.
2. The additional clinical reviewer selected shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions.
3. The selection of the additional clinical reviewer shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers.

The independent review organization shall include in the notice provided:

1. a general description of the reason for the request for external review;
2. the written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;
3. the date the independent review organization received the assignment from the Director to conduct the external review;
4. the time period during which the external review was conducted;
5. the date of its decision;
6. the principal reason or reasons for its decision; and
7. the rationale for its decision.

Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, we shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

The assignment by the Director of an approved independent review organization to conduct an external review shall be done on a random basis among those independent review organizations approved by the Director.

Binding Nature of External Review Decision
An external review decision is binding on us. An external review decision is binding on the *covered person* except to the extent the *member* has other remedies available under applicable federal or State law. A *member* or the *member's authorized representative* may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the *member* has already received an external review.

If a *member* has a change in medical status for a treatment or procedure not previously approved, the *member* may become eligible for a subsequent external review.

Disclosure Requirements
We shall include a description of the external review procedures in, or attached to, the *contract*, and outline of coverage or other evidence of coverage it provides to *members*.

The description required shall include a statement that informs the *covered person* of the right of the *member* to file a request for an external review of an adverse determination or final adverse determination with the Director. The statement shall explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness. The statement shall include the toll-free telephone number and address of the Office of Consumer Health Insurance within the Department of Insurance.

Appeals and Grievances filing and key communication timelines

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

GENERAL PROVISIONS

Entire Contract
This *contract,* with the application*,* is the entire *contract* between you and us*.* No agent may:

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

Non-Waiver
If we or you fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *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 intentional 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 signed by a *member;*
2. A copy of the application has been furnished to the *member(s),* or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to our determination to issue coverage to any *member.* A *member's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. "Rescind" has a retroactive effect and means the coverage was never in effect.

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

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

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

We protect all oral, written and electronic PHI. We follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. We are required to notify you about these practices every year. This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. If you need more information or would like the complete notice, please visit www.ambetterofillinois.com/privacy-practices.html or call Member Services at 1-855-745-5507 (TTY 1-844-517-3431).

We protect all of your PHI. We follow HIPAA to keep your health care 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 www.ambetterofillinois.com/language-assistance.html.

Statement of Non-Discrimination

Ambetter of Illinois insured by Celtic Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter of Illinois insured by Celtic Insurance Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter of Illinois insured by Celtic Insurance Company:

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

If you need these services, contact Ambetter of Illinois insured by Celtic Insurance Company at 1-855-745-5507 (TTY 1-844-517-3431).

If you believe that Ambetter of Illinois insured by Celtic Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a *grievance* with: Ambetter of Illinois insured by Celtic Insurance Company, Attn: Appeals and Grievances, PO Box 10341, Van Nuys, CA 91410, 1-855-745-5507 (TTY 1-844-517-3431), Fax 1-833-886-7956. You can file a *grievance* by mail or fax. If you need help filing a *grievance*, Ambetter of Illinois insured by Celtic Insurance Company 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 (TTY).

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

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter of Illinois insured by Celtic Insurance Company, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Polish:	Jeżeli ty lub osoba, której pomagasz, macie pytania na temat Ambetter of Illinois insured by Celtic Insurance Company, macie prawo poprosić o bezpłatną pomoc i informacje w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter of Illinois insured by Celtic Insurance Company 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-855-745-5507 (TTY/TDD 1-844-517-3431)。
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter of Illinois insured by Celtic Insurance Company에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-855-745-5507 (TTY/TDD 1-844-517-3431) 로 전화하십시오.
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter of Illinois insured by Celtic Insurance Company, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter of Illinois insured by Celtic Insurance Company، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter of Illinois insured by Celtic Insurance Company вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Gujarati:	જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter of Illinois insured by Celtic Insurance Company વિશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાાં મદદ અને માહહતી પ્રાપ્ત કરવાનો અહિકાર છે. દુભાહષયા સાથે વાત કરવા માટે 1-855-745-5507 (TTY/TDD 1-844-517-3431) ઉપર કૉલ કરો.
Urdu:	اگر Ambetter of Illinois insured by Celtic Insurance Company کے بارے میں آپ، یا جن کی آپ مدد کررہے ہیں ان کے سوالات ہوں تو، آپ کو بلامعاوضہ اپنی زبان میں مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی مترجم سے بات کرنے کے لیے، 1-855-745-5507 (TTY/TDD 1-844-517-3431) پر کال کریں
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter of Illinois insured by Celtic Insurance Company, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Italian:	Se lei, o una persona che lei sta aiutando, avesse domande su Ambetter of Illinois insured by Celtic Insurance Company, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l'1-855-745-5507 (TTY/TDD 1-844-517-3431).
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter of Illinois insured by Celtic Insurance Company के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्रा त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-855-745-5507 (TTY/TDD 1-844-517-3431) पर कॉल करें।
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter of Illinois insured by Celtic Insurance Company, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Greek:	Εάν εσείς ή κάποιος που βοηθάτε, έχετε ερωτήσεις σχετικά με την Ambetter of Illinois insured by Celtic Insurance Company, έχετε το δικαίωμα να ζητήσετε βοήθεια και πληροφορίες στη γλώσσα σας, χωρίς χρέωση. Για να μιλήσετε με διερμηνέα, καλέστε το 1-855-745-5507 (TTY/TDD 1-844-517-3431).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter of Illinois insured by Celtic Insurance Company hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-855-745-5507 (TTY/TDD 1-844-517-3431) an.