ambetter. FROM sunflower health plan.
Insured by Celtic Insurance Company

2023 Evidence of Coverage

Ambetter + Adult Vision + Adult Dental

Ambetter.SunflowerHealthPlan.com

THIS *CONTRACT* REFLECTS THE KNOWN REQUIREMENTS FOR COMPLIANCE UNDER THE AFFORDABLE CARE ACT AS PASSED ON MARCH 23, 2010. AS ADDITIONAL GUIDANCE IS FORTHCOMING FROM THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND THE KANSAS INSURANCE DEPARTMENT, THOSE CHANGES WILL BE INCORPORATED INTO YOUR HEALTH INSURANCE POLICY.

AMBETTER FROM SUNFLOWER HEALTH PLAN
Ambetter + Adult Vision + Adult Dental
Individual EPO Health Benefit Plan
Underwritten by Celtic Insurance Company

Home Office:
8325 Lenexa Dr.
Suite 410,
Lenexa, KS 66214
Phone No. 1-844-518-9505
Ambetter.sunflowerhealthplan.com
Claims Office: P.O. Box 5010, Farmington, MO 63640-5010

Individual Major Medical Expense Insurance Policy

In this *contract,* the terms you or your will refer to the *member* or *dependent member*s enrolled in this *contract*, and we, our, or us will refer to Celtic Insurance Company or Ambetter from Sunflower Health Plan.

AGREEMENT AND CONSIDERATION

In consideration of your application and the timely payment of premiums, we will pay benefits to you, the *member*, for *covered services* as outlined in this *contract* and the corresponding *Schedule of Benefits*. 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 *covered services*.

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

Annually, we may 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 *contract* plan, and age of *members,* type and level of

benefits, and place of *residence* on the premium due date are some of the factors used in determining your premium rates. We have the right to change premiums, however, all premium rates charged will be guaranteed for a rating period of at least 12 months.

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

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

TEN DAY RIGHT TO RETURN POLICY

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*.

IMPORTANT NOTICE:

Please read the copy of the application attached to this *contract*. Carefully check the application and write to P.O. Box 5010, Farmington, MO 63640-5010 within ten days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. This application is a part of the *contract* and the *contract* was issued on the basis that answers to all questions and the information shown on the application are correct and complete.

IMPORTANT INFORMATION

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

The coverage represented by this *contract* is under the jurisdiction of the Kansas Insurance Commissioner.

EPO is an abbreviation for *Exclusive Provider Organization*. What that means to you is services must be provided by a *network provider* to be covered except for *emergency services* and certain *mental health* office visits. You may pay 100 percent of the *out-of-pocket cost* up to your *out-of-pocket maximum* for these limited *covered services* provided by *non-network providers*.

This contract does not include pediatric dental services. Please contact your *insurance carrier or producer, or seek assistance through Healthcare.gov, if* you *wish to purchase pediatric dental coverage or a stand-alone dental services product.*

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

Celtic Insurance Company

Kevin J. Counihan, President

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INTRODUCTION

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

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

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

Because many of the provisions are interrelated, you should read this entire *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 in the Definitions section. This *contract* also contains exclusions, so please be sure to read this entire *contract* carefully.

How to Contact Us
Ambetter from Sunflower Health Plan
8325 Lenexa Dr.
Suite 410
Lenexa, KS 66214

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

Member Services	**1-844-518-9505**
TTY line	**1-844-546-9713**
Emergency	**911**
24/7 Nurse Advice Line	**1-844-518-9505**

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

Our interpreter services are provided at no cost to you. We have representatives that speak Spanish and have medical interpreters to assist with languages other than English via phone. An interpreter will not go to a *provider's* office with you. *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 1-844-518-9505, or for the hard of hearing at (TTY 1-844-546-9713).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting you as a *member*.
2. Encouraging open discussions between you, and your *provider(s)*.
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 contracted Ambetter *provider*. *Network providers* may be affiliated with different *hospitals*. Our online directory can provide you with information on 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 provider directory at www.Ambetter.SunflowerHealthPlan.com.

You have the right to:

1. Participate with your *providers* in decisions about your health care. This includes working on any treatment plans and making care decisions. You should know any possible risks, problems related to recovery, and the likelihood of success. You shall not have any treatment without consent freely given by you or your legally *authorized representative*. You will be informed of your care options.
2. Know who is approving and performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which you have coverage.
4. Be treated with respect and dignity.
5. Privacy of your personal health information, consistent with state and federal laws, and our policies.
6. Receive information or make recommendations, including changes, about our organization and services, our *network* of *providers*, 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. Voice *complaints* or *grievances* about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
9. See your medical records.
10. Be kept informed of *covered* and non-*covered services*, program changes, how to access services, *PCP* assignment, *providers*, advance directive information, *authorizations*, benefit denials, *member* rights and responsibilities, and our other rules and guidelines. We will

notify you at least 60 days before the *effective date* of the modifications. Such notices shall include:
    a. Any changes in clinical review criteria; or
    b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
11. A current list of *network providers*.
12. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
13. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, ethnicity, race, religion, gender, sex, sexual orientation, national origin, physical or mental disability, or expected health or genetic status.
14. Access *medically necessary* urgent and *emergency services* 24 hours a day and seven days a week.
15. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.
16. Refuse treatment to the extent the law allows without jeopardizing future treatment, and be informed by your *provider(s)* of the medical consequences. 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.
17. 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.
18. Know the name and job title of people giving you care. You also have the right to know which *physician* is your *PCP*.
19. An interpreter when you do not speak or understand the language of the area.
20. A second opinion by a *network provider,* if you want more information about your treatment or would like to explore additional treatment options.
21. Make advance directives for health care decisions. This includes planning treatment before you need it.
22. Determine what actions should be taken regarding your health if you are no longer able to make decisions for your health 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. They 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. *Member*s also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive.

You have the responsibility to:
1. Read the entire *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 I.D. 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. Provide all information about any other medical coverage you have upon enrollment in this plan. If, at any time, you get other medical coverage besides this coverage, you must tell the entity with which you enrolled.
13. Pay your monthly premium on time and pay all *deductible amounts, copayment amounts*, or *coinsurance amounts* at the time of service.
14. Inform the entity in which you enrolled for this *contract* if you have any changes to your name, address, or family members covered under this *contract* within 60 days from the date of the event. These changes can also be registered by logging into your consumer dashboard on enroll.ambetterhealth.com.
15. Notify us or the entity you enrolled with of any enrollment related changes that would affect your *contract* within 60 days 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 Ambetter.sunflowerhealthplan.com. We have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide you health care services. You can find any of our *network providers* by visiting our website and using the "Find a Provider" function. There you will have the ability to narrow your search by *provider* specialty, zip code, gender, languages spoken, and whether or not they are currently accepting new patients. Your search will produce a list of *providers* based on your search criteria and will give you other information such as name, address, phone number, office hours, specialty, and board certifications.

At any time, you can request a printed copy of the provider directory at no charge by calling Member Services at 1-844-518-9505 (TTY 1-844-546-9713). 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 1-844-518-9505 (TTY 1-844-546-9713). We will help you make the appointment.

Member Identification Card
We will mail you a *member* identification card after we receive your completed enrollment materials, which includes receipt of your initial premium payment. This card is proof that you are enrolled in an Ambetter from Sunflower Health Plan. You need to keep this card with you at all times. Please show this card every time you go for any service under the *contract*.

The *member* identification card will show your name, *member* identification number, and *copayment amounts* required at the time of service. If you do not get your *member* identification card within a few weeks after you enroll, please call Member Services at 1-844-518-9505 (TTY 1-844-546-9713). We will send you another card. A temporary member identification card can be downloaded from www.Ambetter.SunflowerHealthPlan.com.

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

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

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 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 that includes *network providers* to help us develop and monitor our program activities.
5. Investigating any *member* concerns regarding care received.

For example, if you have a concern about the care you received from your *network physician* 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.

As innovative technologies and solutions are established 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*.

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*.

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. Advance payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit payments to apply to your premiums each month, up to the maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you are due, you will get the difference as a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

Adverse benefit determination means:

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

Allowed amount (also see ***Eligible Expense***) 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 amounts*) per the *member's* benefits. This amount excludes any payments made to the *provider* by us as a result of Federal or State arbitration. In the event a *provider* exercises their right to arbitration to come to an agreement on the amount to be paid, the *member* cost share will be calculated on the original *allowed amount*.

Please note, if you receive services from a *non-network provider*, you may be responsible for the difference between the amount the *provider* charges for the service (*billed amount*) and the *allowed amount* that we pay. However, you will not be responsible for *balance billing* for unanticipated out-of-*network* care that is otherwise covered under your plan and that is provided by *a non-network provider* at an in-*network* facility, unless you gave informed consent before receiving the services. You also will not be responsible for *balance billing* by a *non-network provider* or *non-network facility* for *emergency services* or air ambulance services. See *balance billing* and *non-network provider* definitions for additional information. If you are balance billed in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.

Ambetter Telehealth means the preferred vendor who we have contracted with to provide *telehealth services* to *members*. Our preferred vendor contracts with *providers* to render *telehealth services* to *members*. These services can be accessed via https://ambetter.sunflowerhealthplan.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.

Applicable laws means laws of the state in which your contract was issued and/or federal laws.

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

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

Authorization or ***Authorized*** means our decision to approve the *medical necessity* or the appropriateness of care for an member by the *member*'s *primary care physician (PCP)* or *provider*. *Authorizations* are not a guarantee of payment.

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

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

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

If you are ever balance billed for *covered services* 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.

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

Care management means a program in which a registered nurse, known as a care manager, assists a *member* through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and 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*.

Claimant means the *member* or *member's authorized representative* who has contacted the plan to file a *grievance* or *appeal* or who has contacted the Kansas Department of Insurance to file an external review.

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

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*; and
2. An *emergency* cesarean section or a *non-elective cesarean section*.

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

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

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

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

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

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

Cost sharing reductions means reductions in *cost sharing* for an eligible individual *enroll*ed in a silver level plan in the Health Insurance Marketplace or for an individual who is an American Indian and/or Alaskan Native enrolled in a *qualified health plan* (*QHP*) in the Health Insurance Marketplace.

Covered service or ***covered service expenses*** means health care services, supplies or treatment as described in this *contract* which are performed, prescribed, directed or *authorized* by a *physician.* To be a *covered service* the service, supply or treatment must be
1. Incurred while the *member's* insurance is in force under this *contract*;
2. Covered by a specific benefit provision of this *contract*; and
3. Not excluded anywhere in this *contract*.

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

Custodial care includes but is not limited to the following:

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

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

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

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

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

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

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

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

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

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

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

1. A natural child;
2. A legally adopted child;
3. A step child;
4. A foster child placed in your custody;
5. A child placed with you for adoption; or
6. A child for whom legal guardianship has been awarded to you, or your *spouse* or domestic partner.

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

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

1. For *network providers*: When a *covered service* is received from a *network provider*, the *eligible expense* is the contracted fee with that *provider*.
2. For *non-network providers,* unless otherwise required by Federal or Kansas law, the *eligible expense* is as follows:
    a. When a *covered emergency service* or 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. 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.
    b. When a *covered service* is received from a *non-network* professional *provider* who renders non-*emergency services* at an in-*network facility*, the *eligible 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.
    c. 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.
    d. When a covered air ambulance service is received from a non-network provider, the eligible service expense is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full. If the provider has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by applicable law, the eligible service expense is reimbursement as determined by us

and as required by applicable law. Member cost share will be calculated from the recognized amount based upon applicable law. You 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.

Emergency or ***emergency medical condition*** means a medical condition manifesting itself by a sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide immediate medical attention would result in:

1. Placing the health of the *member* or, with respect to a pregnant *member*, the health of the *member* or their unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency services means the effective and coordinated delivery of such care as may be required by an *emergency* that includes *emergency* ambulance services and the performance of *authorized emergency* care by a *physician*, advanced practice registered nurse, professional nurse, a licensed *physician* assistant or *emergency* medical service *provider*.
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 non*emergency* medical transportation, and (b) your *provider* obtains informed consent to provide the additional services.

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

Expedited Appeal means a situation in which a *physician* with knowledge of the *member*'s medical condition determines that the standard timeframe for an *appeal* decision could seriously jeopardize the life or health of the *member* or the *member*'s ability to regain maximum function, or would subject the *member* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. Ongoing *emergency* or continued hospitalization appeals will follow the *expedited appeals* process.

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;
c. It has FDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a FDA-approved drug is a use that is determined by us to be:
    i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
    ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
    iii. Not an *unproven service;* or
d. It has FDA approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the FDA or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*

4. *Experimental* or *investigational* according to the *provider's* research protocols.

Items (3) and (4) above do not apply to phase III or IV FDA clinical trials.

Extended care facility means an institution, or a distinct part of an institution, that:
1. Is operated pursuant to law as a *hospital*, *extended care facility*, or *rehabilitation facility* by the state in which it operates;
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *physician* and the direct supervision of a registered nurse;
3. Maintains a daily record on each patient;
4. Has an effective *utilization review* plan;
5. Provides each patient with a planned program of observation prescribed by a *physician;* and
6. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing *generally accepted standards of medical practice* for that condition.

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

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 expense* 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 verbally or in writing in any form to the insurer by, or on behalf of, a *claimant* including any of the following:
1. Provision of services;
2. Determination to reform or rescind a *contract*; and
3. Claims practices.

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

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

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

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

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

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

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

Hospice means to services designed for and provided to *members* who are not expected to live for more than six months, as certified by a *network physician*. We work with certified *hospice* programs licensed by the state to minimize patient discomfort and address the special physical, psychological, and social needs of *terminally ill 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-h*our* 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 place for the aged, drug addicts, alcoholics, or runaways; a facility for wilderness or outdoor programs; or a similar establishment.

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

Illness means a sickness, disease, or disorder of a *member*.

Immediate family means the parents, *spouse*, domestic partner, *eligible child*, or siblings of any *member*.

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

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

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

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

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

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

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

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

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

Medical practitioner includes but is not limited to a *physician*, nurse anesthetist, *physician*'s assistant, physical therapist, or midwife. The following are examples of *providers* that are NOT *medical practitioners*, by definition of the *contract:* rolfer, hypnotist, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Medically necessary or ***medical necessity*** means our decision as to whether any medical service, supply or treatment *authorized* by a *physician* to prevent, stabilize, diagnose or treat a *member*'s *illness or injury* which:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
7. Is no more costly than an alternative *Covered service* that is likely to produce equivalent therapeutic outcome; and
8. When specifically applied to a *hospital* confinement, it means that the diagnosis and treatment of your medical symptoms or conditions cannot be safely provided as an *outpatient*.

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

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

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

Mental health disorder means a condition that causes disturbance in behavior, emotion, and cognition. These disorders can vary in impact, ranging from no impairment to mild, moderate or severe impairment. Depending on the severity, they may be accompanied by significant distress that affects an individual's work, school and social relationships. *Mental health disorder* benefits are defined as benefits for items or services for mental health conditions listed in the International Classification of Diseases, Tenth Revision (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 plans, most individual plans sold outside of the Health Insurance Marketplace, Medicare, Medicaid, Children Health Insurance Program (CHIP), TRICARE, COBRA and plans sold through the Small Business Health Insurance Program (SHOP) Marketplace.

Necessary medical supplies means medical supplies that are:

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

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

Network means a group of *providers* or *facilities* (including, but not limited to *hospitals*, *inpatient* mental 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 from Sunflower Health Plan 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-elective cesarean section means:

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

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

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

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

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

Outpatient services 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 us. 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 contraceptive services means consultations, examinations, and medical services, provided on an *outpatient* basis and related to the use of contraceptive methods to prevent *pregnancy* which has been approved by the FDA.

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 *member* by blood, marriage or adoption or who is normally a *member* of the *member's* household.

Post-service claim means any claim for benefits for medical care or treatment to which the terms of this *contract* do not condition receipt of the benefit, in whole or in part, on *approval* of the benefit in advance of obtaining the medical care.

Pre-service claim means any claim for benefits for medical care or treatment that requires the *approval* of 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 service expenses*, shown in your *Schedule of Benefits*, if applicable, that must actually be paid during any *calendar year* before any *prescription drug* benefits are payable. The family *prescription drug deductible amount* is two times the individual *prescription drug deductible amount*. For family coverage, once a *member* has met the individual *prescription drug deductible amount*, any remaining family *prescription drug deductible amount* can be met with the combination of any one or more *members' 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), nurse practitioner 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*, another *physician*, or other *provider* prior to the *member* receiving services.

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

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 means a *physician* or other person which is licensed, accredited or certified to perform specified health care services.

Provider facility means a *hospital, rehabilitation facility*, *extended care 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 described in subpart C of part 156 issued or recognized by each Health Insurance Marketplace through which such plan is offered in accordance with the process described in subpart K of part 155.

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

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

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

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

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

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

Rehabilitation licensed practitioner means, but is not limited to, a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation licensed*

practitioner must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

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

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

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

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

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

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

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

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

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

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

Specialist physician is a *physician* or *medical practitioner* who focuses on a specific area of medicine and has additional expertise to help treat specific disorders or *illnesses*. Specialists may be

needed to diagnose, manage, or treat certain types of symptoms and conditions related to their specific field of expertise.

Spouse means the person to whom you are lawfully married.

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

Subscriber means primary individual who applied for this insurance *contract*.

Substance use or ***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* includes synchronous interactions and asynchronous store and forward transfers.

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

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

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*.

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

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

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

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

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

DEPENDENT MEMBER COVERAGE

Dependent Member Eligibility
Your *dependent members* become eligible for insurance 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 a domestic partnership is established, pursuant to state law;
4. The date of an eligible newborn's birth;
5. The date that an adopted child is placed with a *member* for the purposes of adoption or a *member* assumes total or partial financial support of the child; or
6. The date a foster child is placed in your custody.

Effective Date for Initial Dependent Members
The *effective date* for *dependent members,* if any, will be the same as your initial coverage date. Only *dependent members* included in the initial enrollment application for this *contract* will be covered on your *effective date*.

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

Additional premium will be required to continue coverage beyond the 31st day after the date of birth. If notice of the newborn is given to us by the Health Insurance Marketplace within the 31 days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 days after the birth of the child. If notice is given by the Health Insurance Marketplace within 60 days of the birth of the child, 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 that you have enrolled the child in accordance with these *contract* terms.

Coverage for an Adopted Child
An *eligible child* legally placed for adoption with a *member* will be covered from the date of *placement* until the 31st day after *placement,* unless the *placement* is disrupted prior to legal adoption and the child is removed from your or your *spouse's* custody. For a newly born child, coverage will be in place from the date of birth if a petition of adoption is filed within 31 days of the date of birth. For a child adopted within 90 days of birth, delivery and obstetrical expenses of the birth mother will be covered.

The child will be covered on the same basis as any other *dependent member*.

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

As used in this provision, *"placement"* means the date that you or your *spouse* assume physical custody of the child for the purpose of adoption pursuant to an adoption proceeding.

Adding Other Dependent Members
If you are enrolled in an off-Marketplace policy and apply in writing, or directly at www.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 identification cards for the added *dependent member*.

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

If there is no prior coverage or no continuation of *inpatient* coverage after the *effective date*, your Ambetter coverage will apply for *covered services* related to the *inpatient* coverage after your *effective date*. Ambetter coverage requires you notify Ambetter 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 *allowed amount* and you may be billed for any balance of costs above the *allowed amount*.

ONGOING ELIGIBILITY

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

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

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

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 the primary *subscriber* for support.

If you are enrolled through the Health Insurance Marketplace and you have material modifications (examples include a change in life event such as marriage, death or other change in family status), you can log onto your consumer dashboard at enroll.ambetterhealth.com to process these changes.

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

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 directly with us contact Member Services at 1-844-518-9505 (TTY 1-844-546-9713), or you can log onto your Ambetter *member* portal to process these changes. You can log onto your consumer dashboard at enroll.ambetterhealth.com to process these changes.

Special and Limited Enrollment

A *qualified individual* has 60 days to report a qualifying event to the Health Insurance Marketplace or by using Ambetter's *Enhanced Direct Enrollment* tool, and could be granted a 60 day Special Enrollment Period as a result of one of the following events:

1. A *qualified individual* or *dependent member* 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 member* or becomes a *dependent* through marriage, birth, adoption or placement for adoption, placement in foster care, or a child support order or other court order;
    a. In the case of marriage, at least one *spouse* must demonstrate having *minimum essential coverage* as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage.
3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
4. An individual who is no longer incarcerated or whose incarceration is pending the disposition of charges;
5. A *qualified individual's* enrollment or non-enrollment in a *qualified health plan* is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace or HHS, or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
6. A *member* adequately demonstrates to the Health Insurance Marketplace that the *qualified health plan* in which he or she is enrolled substantially violated a material provision of its *contract* in relation to the *member*'s decision to purchase the *qualified health plan* based on plan benefits, *service area* or premium;
7. An individual is determined newly eligible or newly ineligible for *advance payments of the premium tax credit* or has a change in eligibility for *cost sharing reductions*, regardless of whether such individual is already enrolled in a *qualified health plan*;
8. A *qualified individual* or *member* gains access to a new *qualified health plan* as a result of a permanent move;
9. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
10. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a *qualified health plan* or change from one *qualified health 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, that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide;
12. A *qualified individual* or *dependent member* is a victim of domestic abuse or spousal abandonment and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
13. A *qualified individual* or *dependent member* 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;

14. 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 *qualified health plan* through the Health Insurance Marketplace following termination of Health Insurance Marketplace 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;
15. A *qualified individual* newly gains access to an employer sponsored individual coverage HRA (ICHRA)or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA); or
16. Subject to the availability of enhanced tax subsidies, a qualified individual or *member*, or their *dependent member* 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.

In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance payments of the premium tax credit* and *cost sharing reductions*, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where a *qualified individual* experiences a *loss* of *minimum essential coverage*, the *effective date* is the first day of the following month.

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.

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* loses *minimum essential coverage*, coverage is effective on the first day of the following month.

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

If a *qualified individual*, *member*, or *dependent member* 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 member* 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 member* 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 member* 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 member*, the Health Insurance Marketplace must provide the earliest effective that would have been available, based on the applicable qualifying event.

PREMIUMS

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

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

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

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

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

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

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

Health Savings Account (HSA)
A Health Savings Account (HSA) is a special tax-exempt custodial account or trust owned by a *member* where contributions to the account may be used to pay for current and future qualified medical expenses. Please refer to your *Schedule of Benefits* to see if the plan you are enrolled in has an HSA. For members enrolled in an HSA-compatible plan, the following terms apply.

Individual members must satisfy federal HSA eligibility criteria in order to open and contribute to an HSA.

This Evidence of Coverage is administered by Ambetter from Sunflower Health Plan and underwritten by Celtic Insurance Company. Neither entity is an HSA trustee, HSA custodian or a designated administrator for HSAs. Celtic Insurance Company, its designee and its affiliates, including Ambetter from Sunflower Health Plan, do not provide tax, investment or legal advice to members. Refer to IRS guidance for eligible medical expenditures under an HSA.

MEMBERS ARE SOLELY RESPONSIBLE FOR ADHERING TO ALL FEDERAL REGULATIONS AND GUIDELINES CONCERING HSA MAXIMUM ALLOWED AMOUNT, CONTRIBUTIONS AND QUALIFIED WITHDRAWALS. IN ADDITION, EACH *MEMBER* WITH AN HSA IS RESPONSIBLE FOR NOTIFYING HIS/HER HSA CUSTODIAN OR TRUSTEE IF ENROLLMENT UNDER THEIR HSA PLAN HAS BEEN CANCELED OR TERMINATED.

THE TERMS OF THIS EVIDENCE OF COVERAGE ARE CONFINED TO THE BENEFITS PROVIDED HEREIN AND DO NOT ENCOMPASS ANY INDIVIDIUAL HSA FEE ARRANGEMENTS, ACCOUNT MAINTENANCE OR CONTRIBUTION REQUIREMENTS, APPLICATION PROCEDURES, TERMS, CONDITIONS, WARRANTIES OR LIMITATIONS THERETO, GRIEVANCES OR CIVIL DISPUTES WITH ANY HSA CUSTODIAN OR TRUSTEE.

PLEASE CONSULT A PROFESSIONAL TAX ADVISOR FOR MORE INFORMATION ABOUT THE TAX IMPLICATIONS OF A HSA OR HSA PROGRAM.

Reinstatement
If your *contract* lapses due to nonpayment of premium, it may be reinstated provided:
1. We receive from you a written application for reinstatement within one year after the date coverage lapsed; and
2. The written application for reinstatement is accompanied by the required premium payment.

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

The *Rescission*s provision will apply to statements made on the reinstatement application, based on the date of reinstatement.

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

Misstatement of Age
If a *member's* age has been misstated, the *member's* premium may be adjusted 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 Use
The answer to the *tobacco* question on the enrollment application is material to our correct underwriting. If a *member's use of tobacco* 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 your *Schedule of Benefits* and the *covered services* sections of this *contract*. All benefits we pay will be subject to all conditions, limitations, and *cost sharing* features of this *contract*. *Cost sharing* means that you participate or share in the cost of your health care services by paying *deductible amounts*, *copayment amounts* 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 amount* required for each type of service as well as your *deductible* is listed in your *Schedule of Benefits*.

When you, or a *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*.

Deductible
The *deductible amount* means the amount of *covered service expenses* that must be paid by all *members* before any benefits are payable. If on a family plan, if one *member* of the family meets his or her *deductible*, benefits for that *member* will be paid. The *deductible amount* does not include any *copayment amount* or *coinsurance amount*. Not all *covered service expenses* are subject to the *deductible amount*. See your *Schedule of Benefits* for more details.

Copayment Amounts
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 your *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. *Coinsurance amounts* do not apply toward the *deductible*, but do apply toward your *maximum out-of-pocket amount*.

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

Maximum Out-of-Pocket
You must pay any required *copayments* or *coinsurance amounts* required until you reach the *maximum out-of-pocket amount* shown in your *Schedule of Benefits*. After the *maximum out-of-pocket amount* is met for an individual, we will pay 100 percent of the cost for *covered services*. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket amount*. For the family *maximum out-of-pocket amount*, once a *member* has met the individual *maximum out-*

of-pocket amount, the remainder of the family *maximum out-of-pocket amount* can be met with the combination of any one or more *members' eligible expenses*.
After the *maximum out-of-pocket amount* is met for an individual, Ambetter from Sunflower Health Plan 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 your *Schedule of Benefits*.

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

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

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

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

Refer to your *Schedule of Benefits* for Coinsurance Amounts and Other Limitations
The amount payable will be subject to:

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

Non-Network Liability and Balance Billing
If you receive services from a provider that is *non-network*, you may have to pay more for services you receive. *Non-network providers* may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is known as *balance billing*. This amount is likely more than *network* costs for the same service and might not count toward your annual *maximum out-of-pocket* limit.

When receiving care at an Ambetter *network* facility, it is possible that some *hospital*-based providers (for example, assistant surgeons, hospitalists, and intensivists) may not be under contract with Ambetter as *network* providers. We encourage you to inquire about the providers who will be treating you before you begin your treatment, so that you can understand their *network* participation status with Ambetter.

As a *member* of Ambetter, *non-network providers* should not bill you for *covered services* for any amount greater than your applicable *network cost sharing* responsibilities when:

- You receive a covered *emergency service* or air ambulance service from a *non-network provider*. This includes services you may get after you are in stable condition, unless the *non-network provider* obtains your written consent.
- You receive non-*emergency* ancillary services (*emergency* medicine, anesthesiology, pathology, radiology, and neonatology, as well as diagnostic services (including radiology and laboratory services)) from a *non-network provider* at a *network hospital* or *network* ambulatory surgical facility.
- You receive other non-*emergency services* from a *non-network provider* at a *network hospital*

or *network* ambulatory surgical facility, unless the *non-network provider* obtains your written consent.

ACCESS TO CARE

Primary Care Physician (PCP)
In order to obtain benefits, you must designate a *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:

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

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

You may obtain a list of *PCPs* at our website and using the "Find a Provider" function or by contacting our Member Services department.

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

Changing Your PCP
You may change your *PCP* for any reason, but not more frequently than once a month, by submitting a written request, online at our website at Ambetter.SunflowerHealthPlan.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.

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

Should you need care outside of your *PCP's* office hours, you should call your *PCP*'s office for information on receiving after hours care in your area. If you have an urgent medical problem or question or cannot reach your *PCP* during normal office hours, call our 24/7 nurse advice line at 1-844-518-9505 (TTY 1-844-546-9713). A licensed nurse is always available and ready to answer your health questions. In an *emergency*, call 911 or head straight to the nearest *emergency* room.

Network Availability
Your *network* is subject to change. The most current *network* may be found online at our website or by contacting us at the number shown on your *member* identification card. A *network* may not be available in all areas. If you move to an area where we are not offering access to a *network*, please

contact Member Services prior to moving or as soon as possible. Note that services from *non-network providers* are not *covered services* under this *contract* 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*.

In the event your *network provider* is terminated from the *network* for any reason, continuation of care for a period up to 90 days may be provided. The continuation of such care is *medically necessary* and where the *member* has special circumstances such as a disability, a life threatening *illness* or is in the third trimester of *pregnancy*.

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

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

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

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

Hospital Based Providers
When receiving care at a *network hospital* or other *network* health care facility, it is possible that some *hospital*-based *providers* (for example, assistant surgeons, hospitalists, and intensivists) or other health care professionals or *medical practitioners* 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 *network* status with us. 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*. Please see the "*Eligible Expense*" definition for more information.

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.

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

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.

MAJOR MEDICAL EXPENSE BENEFITS

Ambetter from Sunflower Health Plan provides coverage for health care services for a *member* and/or *dependent members*. Some services require *prior authorization*.

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

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

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

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

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*, an assisted living 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.

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.

Ambulance Service Benefits
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 a skilled nursing, *rehabilitation facility* and *member's* home when *authorized* by Ambetter from Sunflower Health Plan.
4. When ordered by an employer, school, fire or public safety official and the *member* is not in a position to refuse; or
5. When a *member* is required by us to move from a *non-network provider* to a *network provider*.

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

Exclusions:
No benefits will be paid for:

1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Ambulance services provided for a *member's* comfort or convenience.
3. Non-*emergency* transportation excluding ambulances (for example, transport-van, taxi).

Air Ambulance Service Benefits
Covered services will include ambulance services for transportation 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 from Sunflower Health Plan.
4. When ordered by an employer, school, fire or public safety official and the *member* is not in a position to refuse; or
5. When a *member* is required by us to move from a *non-network provider* to a *network provider*.

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

Benefits for air ambulance services are limited to:

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

Prior authorization is not required for *emergency* ambulance transportation. **Note**: non-*emergency* ambulance transportation requires *prior authorization*.

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

Please note: You should not be balance billed for services from a *non-network* ambulance *provider*, beyond your cost share, for air ambulance services.

Autism Spectrum Disorder Expense Benefit
Covered services for *autism spectrum disorder*. 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*.

Spinal Manipulation Services

Chiropractic Services are covered when a *network provider* finds that the services are *medically necessary* to treat or diagnose Neuromusculoskeletal Disorders on an *outpatient* basis. *Covered service expenses* are subject to all other terms and conditions of the *contract*, including *deductible amount* and *cost sharing percentage* provisions.

Clinical Trials for Cancer and Other Life-Threatening Illnesses

Covered service expenses for the routine patient care costs incurred by a *member* enrolled in an approved clinical trial related to cancer, including leukemia, lymphoma, and bone marrow stem cell disorders, or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, if the *member's physician* determines that:

1. The *member* or prospective *member* has been diagnosed with cancer and accepted into a phase I, phase II, phase III or phase IV clinical trial for cancer;
2. The treating *physician* who is providing covered health care services to the *member* recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the *member*;
3. There is no clearly superior non-*investigational treatment* alternative; and
4. Available clinical or preclinical data provide a reasonable expectation that the treatment provided in the clinical trial will be at least as effective as any non-*investigational* alternative.

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

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

Covered service expenses include the costs of:

1. Prevention, diagnosis, treatment, and palliative care of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted;
2. Medical care for an approved clinical trial related to cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, that would otherwise be covered under a health care insurance plan if the medical care were not in connection with an approved clinical trial;
3. Items or services necessary to provide an *investigational* item or service;
4. The diagnosis or treatment of complications;

5. A drug or device approved by the FDA without regard to whether the FDA approved the drug or device for use in treating a patient's particular condition, but only to the extent that the drug or device is not paid for by the manufacturer, distributor, or *provider* of the drug or device;
6. Services necessary to administer a drug or device under evaluation in the clinical trial; and
7. Transportation for the patient that is primarily for and essential to the medical care.

Covered service expenses do not include:

1. A drug or device that is associated with the clinical trial that has not been approved by the FDA;
2. Housing, companion expenses, or other nonclinical expenses associated with the clinical trial;
3. An item or service provided solely to satisfy data collection and analysis and not used in the clinical management of the patient;
4. An item or service excluded from coverage under the patient's health care insurance plan; and
5. An item or service paid for or customarily paid for through grants or other funding.

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

Dental Benefits – Adults 19 years of age or older

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

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

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

Services not covered:

1. Out of *network* services;
2. Dental services that are not necessary or specifically covered;
3. Hospitalization or other facility charges;

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

Diabetic Care
Benefits are available for *medically necessary* services and supplies used in the treatment of diabetes.

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

Dialysis Services
Medically necessary acute and chronic dialysis services are *covered service*s. There are two types of treatment provided you meet all the criteria for treatment. You may receive hemodialysis in an *network* dialysis facility or peritoneal dialysis in your home from a *network provider* when you qualify for home dialysis.

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

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

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

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

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

Benefits for repairs and replacement do not include the following:

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

We may establish reasonable quantity limits for certain supplies, equipment or appliance described below. See your *Schedule of Benefits* for benefit levels or additional limits.

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. We 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. Tracheotomy tube.
6. Cardiac, neonatal and sleep apnea monitors.
7. 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 implant and Bone Anchored Hearing Aids.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (the first one following cancer treatment, not to exceed one per benefit period) when purchased through a health plan DME *provider*.

Exclusions:
Non-covered prosthetic appliances include but are not limited to:
1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Wigs (except as described above following cancer treatment) when purchased through other than a health plan DME *provider*.

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

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

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

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

Family Planning and Contraception
Family planning/contraception benefits are covered under preventive care, without cost sharing (when provided by a contracted provider). These benefits include the following for adolescent and adult women, in accordance with the most recent guidelines supported by HRSA:

- The full range of contraceptives currently identified by the U.S. Food and Drug Administration (FDA), including: (1) sterilization surgery for women, (2) implantable rods, (3) copper intrauterine devices, (4) intrauterine devices with progestin (all durations and doses), (5) injectable contraceptives, (6) oral contraceptives (combined pill), 7) oral contraceptives (progestin only), (8) oral contraceptives (extended or continuous use), (9) the contraceptive patch, (10) vaginal contraceptive rings, (11) diaphragms, (12) contraceptive sponges, (13) cervical caps, (14) condoms, (15) spermicides, (16) emergency contraception (levonorgestrel) and (17) emergency contraception (ulipristal acetate).
- Coverage is also available for any additional contraceptives approved, granted, or cleared by the FDA (if the patient and the patient's attending provider have determined it to be medically appropriate).
- Contraceptive care, such as: screening, education, provision of contraception, counseling and follow-up care (e.g., management, evaluation and changes, including the removal, continuation and discontinuation of contraceptives).
- Instruction in fertility awareness-based methods, including lactation amenorrhea.

Note: Services that are integral to the furnishing of the above-listed preventive care coverage (e.g., anesthesia provided during sterilization surgery for women), are also included under preventive care, regardless of whether the service is billed separately.

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits
Covered expenses include expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:

1. *Covered expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision;
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for

treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay;

3. *Covered expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
    a. Daily room and board and nursing services;
    b. Diagnostic testing; and
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the FDA;
4. *Covered expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners.*
5. *Outpatient rehabilitation/habilitation* therapy may include: occupational, physical, and speech therapy.
6. Coverage for Cardiac and Pulmonary *Rehabilitation*.

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

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

Home Health Care Expense Benefits
Covered services 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. Services of a private duty registered nurse rendered on an *outpatient* basis;
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care;*
4. Intravenous medication and pain medication;
5. *Necessary medical supplies*;
6. Rental of the *durable medical equipment;* and
7. Hemodialysis, and for the processing and administration of blood or blood components;

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

At our option, we may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a *provider* we authorize before the purchase.

Educational visits are limited to three visits per year.

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

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

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

Hospice Care Expense Benefits
Hospice care benefits are allowable for a *terminally ill member* receiving *medically necessary* care under a *hospice care program*. *Respite care* is covered on an *inpatient* or home basis to allow temporary relief to family members from the duties of caring for a *member* under *hospice* care. Respite days that are applied toward the *member* cost share obligations are considered benefits provided and shall apply against any maximum benefit limit for these services. *Covered services* include:

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

Benefits for *hospice inpatient,* home or *outpatient* care are available to a *terminally ill member*. 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.

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

1. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.

2. Daily room and board and nursing services while confined in an *intensive care unit*.
3. *Inpatient* use of an operating, treatment, or recovery room.
4. *Outpatient* use of an operating, treatment, or recovery room for *surgery.*
5. Services and supplies, including drugs and medicines, which are routinely provided by the *hospital* for use only while you are *inpatient.*
6. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See your *Schedule of Benefits* for limitations.

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, ultrasound). *Prior authorization* may be required, see your *Schedule of Benefits* for details. **Note**: Depending on the service performed, two bills may be incurred - both subject to any applicable *cost sharing* - one for the technical component (the procedure itself) and another for the professional component (the reading/interpretation of the results by a *physician* or other qualified practitioner).

Infertility Services
Covered services for infertility treatment are limited to diagnostic testing to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy and semen analysis. Benefits are included to treat the underlying medical conditions that cause infertility (such as endometriosis, obstructed fallopian tubes and hormone deficiency).

Pap Smear Coverage
Covered services include cervical cancer screening when prescribed by your *physician* or *medical practitioner*.

Mammography Coverage
Breast cancer screening mammography, including tomosynthesis or "3D mammography" is provided annually or as prescribed by your *physician* or *medical practitioner.*

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 treatable *mental health disorder*s. These disorders affect the *member*'s ability to cope with the requirements of daily living. If you need mental health or *substance use disorder* treatment, you may choose any *provider* participating in our *behavioral health network* and do not need a referral from your *PCP* in order to initiate treatment. You can search for *network behavioral health providers* by using our Find a Provider tool at Ambetter.SunflowerHealthPlan.com or by calling Member Services at 1-844-518-9505 (TTY 1-844-546-9713). *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 *member*s for the diagnosis and *medically necessary* and active treatment of mental, emotional, or *substance use disorders* as defined in this *contract*.

When making coverage determinations, our *behavioral health* and *substance use disorder* staff utilizes established level of care guidelines and *medical necessity* criteria that are based on *generally accepted standards of medical practice* and take into account legal and regulatory requirements. They utilize ChangeHealthcare'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. Observation;
4. Crisis stabilization;
5. *Inpatient rehabilitation*;
6. *Residential treatment facility* for mental health and *substance use disorders*; and
7. Electroconvulsive Therapy (ECT).

Outpatient

1. Partial Hospitalization Program (PHP)
2. Intensive *Outpatient* Program (IOP);
3. Mental health day treatment;
4. Evaluation and assessment for mental health and *substance use disorder*;
5. Traditional *outpatient services*, including individual and group therapy services;
6. Medication management services;
7. Medication-assisted treatment–combines behavioral therapy and medications to treat *substance use disorders*;
8. *Outpatient* detoxification programs;
9. Psychological and Neuropsychological testing and assessment;
10. *Applied Behavior Analysis* for treatment of Autism;
11. Telehealth;
12. Electroconvulsive Therapy (ECT);
13. Transcranial Magnetic Stimulation; and
14. Assertive Community Treatment.

In addition, Integrated *Care Management* is available for all of your health care needs, including *behavioral health* and *substance use disorders*. Please call 1-844-518-9505 (TTY 1-844-546-9713) 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*.

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. However, we will not require *Prior Authorization* for withdrawal management services or *inpatient* or residential

substance use disorder treatment services. Please see the *Schedule of Benefits* for more information regarding services that require *prior authorization* and specific benefit limits, if any.

Medical and Surgical Expense Benefits

Medical *covered 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 services received for urgent care, including facility charges at an *urgent care center*;
3. For the professional services of a *medical practitioner;*
4. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies;*
5. For diagnostic testing using radiologic, ultrasonographic, or laboratory services;
6. For chemotherapy and radiation therapy or treatment;
7. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components;
8. For the cost and administration of an anesthetic;
9. For oxygen and its administration;
10. For accidental *dental expenses* when a *member* suffers an *injury,* after the *member's effective date* of coverage, that results in:
    a. Damage to his or her natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any *injury* as a result of chewing;
    c. Treatment made necessary due to *injury* to the jaw and oral structures other than teeth are covered without time limit;
11. For reconstructive breast *surgery* charges as a result of a partial or total mastectomy for breast cancer, if the patient elects reconstruction and in the manner chosen by the patient and the *physician*. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic device*s necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas;
12. For *medically necessary manipulative therapy* treatment on an *outpatient* basis only. See your *Schedule of Benefits* for benefit levels or additional limits. *Covered expenses* are subject to all other terms and conditions of the *contract,* including *deductible* and *coinsurance percentage* provisions;
13. For pulse oximetry screening on a newborn;
14. For the following types of tissue transplants:
    a. Cornea transplants;
    b. Artery or vein grafts;
    c. Heart valve grafts;
    d. Prosthetic tissue replacement, including joint replacements;
    e. Implantable prosthetic lenses, in connection with cataracts.
15. For dental procedure coverage for the *medically necessary* facility charges and administration of general anesthesia administered by a licensed anesthesiologist or anesthetist for dental procedures performed on a *member* who:
    a. is a child under the age of six who is determined by a licensed dentist in conjunction with a licensed *PCP* to have a dental condition of significant dental complexity which requires certain dental procedures to be performed in a surgical day care facility or *hospital* setting; or

b. is a person who has exceptional medical circumstances or a developmental disability as determined by a licensed *PCP* which place the person at serious risk;

16. For *medically necessary* services made by a *provider* who renders services in a *network urgent care center*, including facility costs and supplies;
17. For *outpatient contraceptive services* for any type of drug or device for contraception, which is lawfully prescribed and has been approved by the FDA. Additionally, coverage is required for any *outpatient services* related to the use of a drug or device intended to prevent *pregnancy*;
18. 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 *physician* has issued a written order stating that the enteral formula or food product is *medically necessary* and is the least restrictive and most cost effective means for meeting the needs of the *member*. 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;
19. For wigs (not to exceed one per *calendar year*) when purchased through a *network provider*. This coverage is only provided for *members* who suffer from hair loss as a result of an underlying medical condition, treatment or *injury*. Coverage shall be subject to a written recommendation by the treating *physician* stating that the wig is *medically necessary*;
20. 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 as long as the providing therapist receives a referral from the child's *PCP* if applicable;
21. For *medically necessary* diagnostic and laboratory and x-ray tests;
22. For *telehealth* for *covered services* provided within the scope of practice of a *physician* or other health care *provider* as a method of delivery of medical care by which a *member* shall receive medical services from a health care *provider* without in-person contact with the *provider*;
23. For injections, including allergy injections;
24. 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. Surgical services as described in the "Temporomandibular Joint (TMJ) and Craniomandibular Joint Services" section.
    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.*
25. For *medically necessary* genetic blood tests; and
26. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
27. For services related to diagnosis, treatment and management of osteoporosis when such services are provided by a medical *provider* licensed to practice medicine and *surgery* in

Kansas, for *members* with a condition or medical history for which bone mass measurement is *medically necessary* for such individual.

28. For *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis;
29. For testing of pregnant women and other members for lead poisoning;
30. For *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 a *member* in-person. *Telehealth services* provided by *Ambetter Telehealth* vendors are subject to $0 *copay*. *Telehealth services* not provided by *Ambetter Telehealth* vendors are 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;
31. *Medically necessary* nutritional counseling, *prior authorization* may be required;
32. *Medically necessary* routine foot care, *prior authorization* may be required.

Medical Foods

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

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 *member* and the item cannot be modified. If more than one *prosthetic device* can meet a *member'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 *member*;
3. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator;
4. For the purchase or rental of *medically necessary durable medical equipment*;
5. For the cost of one Continuous Passive Motion (CPM) machine per *member* following a covered joint *surgery*;
6. Infusion therapy;
7. For one pair of eyeglasses or contact lenses per *member* following a cataract *surgery*, or if the lens of your eye has been surgically removed or is congenitally absent.

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 us.

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

a. *Outpatient* and *inpatient* pre- and post-partum care including examinations, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, and childbirth classes.

b. *Physician* home visits and office services.
c. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
a. *Complications of pregnancy*.
d. *Hospital* stays for other *medically necessary* reasons associated with maternity care (less any applicable *copayment amounts*, *deductible amounts*, or *coinsurance*).
e. 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 an *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 the **General Limitations and Exclusions** section as limitations may exist.

Newborn Charges
Medically necessary services, including *hospital* services, are provided for a covered newborn child immediately after birth. Each type of *covered service* incurred by the newborn child will be subject to his/her own *cost sharing* (*copayment*, *coinsurance* percentage, *deductible* and *maximum out-of-pocket amount*), as listed in your *Schedule of Benefits*. This *cost sharing* will become effective starting 31 days after the date of the birth. Please refer to the **Dependent Member Coverage** section for details regarding coverage for a newborn child/coverage for an adopted child.

Duty to Cooperate
We do not cover services or supplies related to a *member's pregnancy* when a *member* is acting as a *surrogate* and has entered into a *surrogacy arrangement*. For more information on excluded services, please see the General Limitations and Exclusions section. *Members* who are a *surrogate* at the time of enrollment or *members* who agree to a *surrogacy arrangement* during the plan year must, within 30 days of enrollment or agreement to participate in a *surrogacy arrangement*, send us written notice of the *surrogacy arrangement* to Ambetter from Sunflower Health Plan at the Member Services Department, 8325 Lenexa Dr., Suite 410, Lenexa, KS 66214. 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
If expenses for *hospital* confinement in connection with childbirth are otherwise included as *covered service expenses*, we will not limit the number of days for these expenses to less than that stated in this provision.

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, we may provide benefits for *covered service expenses* incurred for a shorter stay if

the attending *provider* (e.g., your *physician*, nurse midwife or *physician* assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

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

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

1. A *prescription drug; and*
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician.*
3. 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.
4. Self-administered human growth hormones to treat children with short stature who have an absolute deficiency in natural growth hormone. Benefits are also available to treat children with short stature who have chronic renal insufficiency and who do not have a functioning renal transplant.
5. Orally administered anti-cancer medication.

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

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

The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her *physician. Experimental or investigational treatment* drugs will be covered as defined.

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.

Coverage for specialty and non-specialty *prescription drugs* will be limited to a supply sufficient for 34 consecutive days of therapy based on criteria established by us, except *prescription drugs* that are considered maintenance and may be dispensed in supplies up to a maximum of 100 unit dose quantities, but not to exceed a supply sufficient for 100 consecutive days of therapy, if such is greater than a 34 consecutive day supply. The *prescription drugs* received may be subject to *co-payments*, *coinsurance deductible*s, or other *member cost shares*.

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

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

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the formulary. For the most current Ambetter formulary or *prescription drug* list or for more information about our pharmacy program, visit Ambetter.SunflowerHealthPlan.com (under “For Member”, “Drug Coverage”) or call Member Services at 1-844-518-9505 (TTY 1-844-546-9713).

Lock-In Program
To help decrease overutilization and abuse, certain *members* identified through our Lock-In Program, may be locked into a specific pharmacy for the duration of their participation in the Lock-In Program. *Members* locked into a specific pharmacy will be able to obtain their medication(s) only at 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 such *member’s* participation in the program via mail. Such communication will include information on duration of participation, pharmacy to which *member* is locked-in, and any *appeals* rights.

<u>Standard exception request</u>
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 us or a protocol exception for step therapy. The request can be made in writing or via telephone. Within 72 hours of the request being received, we will provide the *member*, the *member’s authorized representative* or the *member’s* prescribing *physician* with our coverage determination. Should the standard exception request or step therapy protocol exception request be granted, we will provide coverage of the non-formulary drug for the duration of the prescription, including refills, or of the drug that is the subject of the protocol exception.

Expedited exception request
A *member*, a *member's 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 an *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 or step therapy protocol exception request be granted, we will provide coverage of the non-formulary drug or the drug that is the subject of the protocol exception for the duration of the exigency.

External exception request review
If we deny a request for a standard exception or for an expedited exception, the *member*, the *member's 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 three business days following receipt of the request, if the original request was a standard exception, and no later than one business day following its receipt of the request, if the original request was an expedited exception.

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

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

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.

Non-Covered Services and Exclusions:
No benefits will be paid under this benefit provision for expenses incurred:

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance, unless listed on the formulary.
2. For immunization agents otherwise not required by the Affordable Care Act.
3. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.

4. For a refill dispensed more than 12 months from the date of a *physician's* order.
5. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
6. 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. This exclusion does not apply to prescribed FDA-approved contraceptive methods.
7. For drugs labeled "Caution - limited by federal law to investigational use" or for *investigational or experimental* drugs.
8. For any drug that we identify as therapeutic duplication through the drug *utilization review* program.
9. For more than a 34-day supply when dispensed in any one prescription or refill, or for maintenance drugs up to 90-day supply when dispensed by any retail or mail order pharmacy, or a pharmacy other than CVS retail or CVS mail that participates in extended day supply *network.* Please note that only the 90 day supply is subject to the discounted *cost sharing*. Mail orders less than 90 days are subject to the standard *cost sharing* amount.
10. For *prescription drugs* for any *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.
11. For foreign Prescription Medications, except those associated with an *emergency medical condition* while you are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this section if obtained in the United States.
12. 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 the drugs or dosage amounts have been approved by any governmental regulatory body for that use.
13. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
14. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventive treatment is related to *member's* vacation for out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
15. For any medications used for cosmetic purposes.
16. 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.
17. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
18. For any injectable medication or biological product that is not expected to be self-administered by the *member* at *member's* place of *residence* unless listed on the formulary.
19. For any drug dispensed from a non-lock-in pharmacy while *member* is in a lock-in program.
20. For medication refills where a *member* has more than 15 days' supply of medication on hand.
21. For weight loss *prescription drug*s unless otherwise listed on the formulary.
22. For any drug elated to dental restorative treatment or treatment of chronic periodontitis where drug administration occurs at dental practitioner's office.
23. For compound drugs, unless there is at least one ingredient that is an FDA-approved drug.
24. For any drug related to *surrogate pregnancy*.
25. For drugs that are administered or entirely used up at the time and place ordered.
26. Prescription drugs for which normally (in professional practice) there is no charge.

27. Prescription drugs for other than human use.
28. For drugs, supplies, and equipment used in intravenous treatment.
29. For prescription drugs covered under another *contract*, certificate, or rider issued by us.
30. For prescription drugs listed as excluded on the formulary. This is in addition to drugs or classes of drugs excluded under the other provisions of this *contract.*
31. For prescription drugs utilized primarily for the stimulation of hair growth. This applies for drugs that are prescribed for purposes other than the stimulation of hair growth.

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.

How to Fill a Prescription
*Prescription order*s can be filled at an *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 Ambetter.SunflowerHealthPlan.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 Ambetter.SunflowerHealthPlan.com. You can also request to have a copy mailed directly to you.

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

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

1. Routine ophthalmological exam
    a. Refraction;
    b. Dilation;
    c. Contact lens fitting.
2. Frames
3. Prescription lenses
    a. Single;
    b. Bifocal;
    c. Trifocal;
    d. Lenticular; or

e. Contact lenses (in lieu of glasses).

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

Please refer to your *Schedule of Benefits* for a detailed list of *cost sharing*, annual maximum and appropriate service limitations. To see which vision *providers* are part of the *network*, please visit Ambetter.SunflowerHealthPlan.com or call Member Services.
Services not covered:

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

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

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual;
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration;
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women;
5. All FDA-approved contraception methods are approved for *member*s without *cost sharing* as required under the Affordable Care Act. *Member*s have access to the methods available and outlined on our Drug Formulary or Preferred Drug List without *cost share*. Some contraception methods are available through a *member*'s medical benefit, including the insertion and removal of the contraceptive device at no *cost share* to the *member*; and
6. Coverage without *cost sharing*:
    a. Screening for *nicotine or tobacco use*; and

b. For those who use *nicotine or tobacco* products, at least two cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
    i. Four *nicotine or tobacco* cessation counseling sessions of at least ten minutes each (including telephone counseling, group counseling and individual counseling) without *prior authorization*; and
    ii. All FDA-approved *nicotine or tobacco* cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care *provider* without *prior authorization*.

Benefits when billed as preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any *deductibles* and *coinsurance* provisions under the *contract* when the services are provided by a *network provider.* Benefits include coverage for smoking cessation counseling and related *prescription drug*s.

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

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

If a service is considered diagnostic or routine chronic care, your *copayment, coinsurance* and *deductible* will apply. It is important to know what type of service you are getting. If non-preventive service is performed during the same health care visit as a preventive service, you may have *copayment* and *coinsurance* charges.

Transplant Service Expense Benefits
Covered services for transplant expenses:
Transplants are a *covered service* when a *member* is accepted as a transplant candidate and pre-*authorized* in accordance with this *contract*. *Prior authorization* must be obtained through the "*Center of Excellence*" before an evaluation for a transplant. We may require additional information such as testing and/or treatment before determining *medical necessity* for the transplant benefit. *Authorization* must be obtained prior to performing any related services to the transplant *surgery*. Transplant services must be provided by a *network provider* and facility, and meet other medical criteria as set by medical management policy and the medical *providers* performing the transplant.

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

1. If both the donor and recipient have coverage provided by the same insurer each will have their benefits paid by their own coverage program.
2. If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this *contract* will be provided for both you and

the donor. In this case, payments made for the donor will be charged against *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* is an appropriate candidate for a *medically necessary* transplant*,* Medical Benefits *covered expenses* will be for:

1. Pre-transplant evaluation;
2. Pre-transplant harvesting of the organ from the donor;
3. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant);
4. *Outpatient covered services* related to the transplant *surgery*, pre-transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection and other immunosuppressive drug therapy, etc.;
5. Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *member* to prepare for a later transplant, whether or not the transplant occurs;
6. The transplant itself, including the acquisition cost for the organ or bone marrow when authorized through a *Center of Excellence*;
7. 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;
8. Post-transplant follow-up and treatments.
9. 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;
10. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors;
11. 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 (Ambetter.SunflowerHealthPlan.com/resources/handbooks-forms.html)

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

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

Ancillary "*Center of Excellence*" Benefits:
A *member* may obtain services in connection with a *medically necessary* transplant from any *physician*. However, if a *medically necessary* 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 75 miles from the *residence* to the *Center of Excellence*:
2. We will pay a maximum of $10,000 per transplant service for the following services:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence.*
    b. 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.* 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 six months of the date of service in order to be reimbursed.

c. When *member* and/or donor is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
d. 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.
e. Incurred costs related to a certified/registered service animal for the transplant *member* and/or donor.
f. Please refer to the *member* resources page for *member* reimbursement transplant travel forms and information at Ambetter.SunflowerHealthPlan.com.

Exclusions:
No benefits will be paid under these Transplant Expense Benefits for charges:

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *medically necessary* transplant occurs;
2. For animal to human transplants;
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the *Center of Excellence*;
4. To keep a donor alive for the transplant operation;
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 not included under this provision as a *medically necessary* transplant; and
7. For a *medically necessary* 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. **Note**: This exclusion does not apply to bone marrow transplants.
8. The acquisition cost for the organ or bone marrow when provided at an *authorized* facility or not obtained through the *Center of Excellence*.
9. For any transplant services and/or travel related expenses for *member* and donor when performed outside of the United States.
10. The following ancillary items listed below will not be subject to the *member* reimbursement under this *contract*:
    a. Alcohol/*tobacco*
    b. Car Rental (unless pre-approved by Case Management)
    c. Vehicle Maintenance for motorized and hybrid and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.)
    d. Parking, such as but not limited to hotel, valet or any offsite parking other than *hospital*.
    e. Storage rental units, temporary housing incurring rent/mortgage payments.
    f. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
    g. Speeding tickets
    h. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
    i. For any services related to pet care, boarding, lodging, food, and/or travel expenses; other than those related to certified/registered service animal(s).
    j. Expenses for persons other than the patient and his/her covered companion

k. Expenses for lodging when *member* is staying with a relative
l. Any expense not supported by a receipt
m. Upgrades to first class travel (air, bus, and train)
n. Personal care items (e.g., shampoo, deodorant, clothes)
o. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA pre-check, and early check-in boarding fees, extra baggage fees.
p. Souvenirs (e.g., t-shirts, sweatshirts, toys)
q. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type.
r. All other items not described in the *contract* as *eligible expenses*
s. Any fuel costs/charging station fees for electric cars.

Limitations on Transplant Expenses Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

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.

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

1. Whenever a minor *surgical procedure* is recommended to confirm the need for the procedure;
2. Whenever a serious *injury* or *illness* exists; or
3. Whenever you find that you are not responding to the current treatment plan in a satisfactory manner.

If requested, the second opinion consultation is to be provided by a *network physician* of the *member's* choice. If a *member* chooses a *network physician*, he or she will only be responsible for the applicable *cost sharing* for the consultation; however, any lab tests and/or diagnostic and therapeutic services are subject to the additional *cost sharing*. If a *member* selects a *non-network*

physician, the services are not covered and the *member* is responsible for payment of all services and items.

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 members. 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 Ambetter.SunflowerHealthPlan.com or by contacting Member Services at 1-844-518-9505 (TTY 1-844-546-9713).

Urgent Care Service Benefits
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 contracted *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 1-844-518-9505 (TTY 1-844-546-9713). 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.

Vision Benefits – Adults 19 years of age or older
Coverage for vision services is provided for adults, age 19 and older, from a *network provider*.

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

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

Services not covered:

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

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 Ambetter.SunflowerHealthPlan.com or by contacting Member Services at 1-844-518-9505 (TTY 1-844-546-9713). 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 automatically eligible for program benefits upon obtaining coverage. The programs are optional, and the benefits are made available at no additional cost to the members. The programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change by us through updates available on our website or by contacting us.

Care Management Programs

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

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

Your care manager will work with you and your doctor to help you get the care you need. If you have a severe medical condition, your care manager will work with you, your *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 1-844-518-9505 (TTY 1-844-546-9713).

PRIOR AUTHORIZATION

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

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

Prior Authorization Required

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

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

1. Receives a service or supply from a *non-network provider;*
2. Is admitted into a *network* facility by a *non-network provider;* or
3. Receives a service or supply from a *network provider* to which the *member* was referred by a *non-network provider.*

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

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

Prior authorization must be obtained for the following services, except for urgent care or *emergency services*. This list is not exhaustive, to confirm if a specific service requires *prior authorization*, please contact Member Services.

- Non-*emergency* health care services provided by *non-network providers*;
- Reconstructive procedures;
- Diagnostic tests such as specialized labs, procedures and high technology imaging;
- Injectable drugs and medications;
- *Inpatient* health care services;
- Specific *surgical procedures*;
- Nutritional supplements;
- Pain management services; and
- Transplant services.

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 (1 calendar day) of receipt of the request.

2. For urgent pre-service reviews, within 72 hours (3 calendar days) from date of receipt of request.
3. For non-urgent pre-service reviews within 15 calendar days of receipt of the request.
4. For post-service or retrospective reviews, within 30 calendar days of receipt of the request.

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

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. Please see your *Schedule of Benefits* for specific details.

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

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

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

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

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

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

Services from Non-Network Providers
Except for *emergency* medical services, services from *non-network providers* are not *covered services* unless we have given *prior authorization*. If required *medically necessary* services are not available from *network providers,* **you or the *network provider* must request *prior authorization* from us before you may receive services from *non-network providers*.** Otherwise you will be responsible for all charges incurred.

GENERAL LIMITATIONS AND EXCLUSIONS

No benefits will be paid for:

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

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

1. Administered or ordered by a *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 expenses will not include, and no benefits will be 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 weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*;
4. For cosmetic breast reduction or augmentation except for the *medically necessary* treatment of gender dysphoria;
5. For reversal of sterilization and vasectomies;
6. For abortion unless the life of the mother would be endangered if the fetus were carried to term;
7. For artificial insemination (AI), assisted reproductive technology (ART) procedures or the diagnostic tests and drugs to support AI or ART procedures;
8. For expenses for television, telephone, or expenses for other persons;
9. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions;
10. For telephone consultations between providers, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
11. For stand-by availability of a *medical practitioner* when no treatment is rendered;
12. For *dental expenses,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Medical Benefits;
13. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect in a child;
14. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Expense Benefits;
15. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism;

16. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services unless expressly provided for by the *contract*;
17. For vocational or recreational therapy, vocational *rehabilitation*, *outpatient* speech therapy, or occupational therapy, except as expressly provided for in this *contract*;
18. For eyeglasses, contact lenses, *hearing aid*s, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the *contract*;
19. For *experimental or investigational* treatment(s) or *unproven services.* The fact that an *experimental or investigational* treatment or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational* treatment or *unproven service* for the treatment of that particular condition.
20. For procedures and diagnostic tests that are considered to be obsolete by a professional medical-advisory committee;
21. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency;
22. As a result of an *injury* or disease arising out of, or in the course of, acts of war, insurrection, rebellion, armed invasion or aggression;
23. For or related to *surrogate* parenting;
24. For any services performed by a member of the *member's immediate family*;
25. For fetal reduction *surgery*;
26. Except as specifically identified as a *covered expense* under the *contract*, expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health;
27. For the following miscellaneous items, unless specifically described in this *contract*: artificial insemination except where required by federal or state law; care or complications resulting from non-*covered service expenses*; 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; skilled nursing facilities; private duty nursing; *rehabilitation* services for the enhancement of job, athletic or recreational performance; routine or elective care outside the *service area*; treatment of spider veins; transportation expenses;
28. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment;
29. Services or supplies eligible for payment under either federal or state programs (except Medicaid). This exclusion applies whether or not you assert your rights to obtain this coverage or payment of these services; and
30. Mental Health Services are excluded for the following:
    a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless a plan *physician* determines such evaluation to be *medically necessary*.

b. When ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless a plan *physician* determines such Services to be *medically necessary*.
c. Court-ordered testing and testing for ability, aptitude, intelligence or interest.
d. Services which are custodial or residential in nature.
e. Services provided for mental health services by a provider that is not licensed/certified by the state in which care is being rendered and performing services within the scope of that license/certification.

31. For services associated with any mass screening type of physical or health examinations except for pap smears and mammograms performed at a mobile facility certified by the Centers for Medicare and Medicaid Services (e.g. mass screenings at mobile vans and school testing programs);
32. *Surrogacy arrangement*. Health care services, including supplies and medication, to a *Surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a *member*, and any child born as a result of a *surrogacy arrangement*. This exclusion applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the *surrogate* following childbirth);
    d. Mental Health Services related to the surrogacy arrangement;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
    h. Preimplantation genetic diagnosis relating to a surrogacy arrangement;
    i. Any complications of the child or *surrogate* resulting from the *pregnancy*; or
    j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*.

    Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except where the child is the adoptive child of *members* possessing an active *contract* with us and/or the child possesses an active *contract* with us at the time of birth.
33. For any medicinal and recreational use of cannabis or marijuana.
34. For all health care services obtained at an *urgent care facility* that is a *non-network provider*.
35. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Medical and Surgical Expense Benefits provisions.
36. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
37. For any product that reasonably could be expected to be non-self-administered or for products that should be administered in a medical facility.
38. Immunizations that are not *medically necessary* or medically indicated. This includes those used for travel and occupational uses.
39. For expenses, services, and treatments from a massage therapist to touch and manipulate the muscles and other soft tissues of the body.

40. 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.
41. For expenses, services, and treatments from a Naturopathic specialists for treatment of prevention, self-healing and use of natural therapies.
42. For expenses, services, and treatments related to private duty nursing in an *inpatient*, *outpatient* or home location.
43. For expenses or services related to dry needling.
44. For expenses related to autopsies, unless the autopsy is requested by us;
45. Diagnostic tests and evaluations that are ordered, requested or performed solely for the purpose of resolving issues in the context of legal proceedings. This includes issues concerning custody, visitation, termination of parental rights, civil damages or criminal actions;
46. For services of volunteers;
47. For prostheses that require surgical insertion into the body and billed by an entity or person that is not the *hospital* or ambulatory surgical center where the surgery was performed;
48. For expenses, services, and treatments related to autogenic biofeedback;
49. For adult eye examinations to determine the need for vision correction, unless the services are used for the treatment of diabetes;
50. Charges for completion of insurance claim forms;
51. For laboratory services performed by an independent laboratory that is not approved by Medicare;
52. For travel expenses, mileage, time spent traveling, telephone calls, charges for services provided over the telephone, services provided through e-mail or electronic communications.

TERMINATION

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

1. Nonpayment of premiums when due, subject to the grace period provision in this *contract*.
2. The date we receive a request from you to terminate this *contract,* or any later date stated in your request, or if you are enrolled through the Health Insurance Marketplace, the date of termination that the Health Insurance Marketplace provides us upon your request of cancellation to the Health Insurance Marketplace.
3. For a covered *eligible child* reaching the limiting age of 26, coverage under this *contract* will terminate at 11:59 p.m. on the last day of the year in which the covered *eligible child* turns age 26.
4. The date we decline to renew this *contract,* as stated in the Discontinuance provision.
5. The date of your death, if you are the only *member* on this *contract*.
6. The date your eligibility for insurance under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.
7. The date your eligibility for coverage under this *contract* ceases as determined by the Health Insurance Marketplace.

If there are other *members* covered under this *contract*, it may be continued after your death:

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

This *contract* will be changed and your *spouse* or youngest child will replace you as the primary *subscriber*. A proper adjustment will be made in the premium required for this *contract* to be continued. We will also refund any premium paid and not earned due to your death. The refund will be based on a pro-rata basis.

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 in 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. 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 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. 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 policies/certificates in the individual market in the state where you reside, we will provide a written notice to you and the Commissioner of Insurance at

least 180 days prior to the date that we stop offering and terminate all existing individual policies in the individual market in the state where you reside.

Notification Requirements
It is the responsibility of you or your former *spouse* to notify the Health Insurance Marketplace or us within 31 days of your legal divorce.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its *contract* terms without regard to the possibility that *another plan* may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans does not exceed 100 percent of the total allowable expense.

DEFINITIONS

1) A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for *members* of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan includes:

1. Group insurance contracts and *subscriber* contracts;
2. Uninsured arrangements of group or group-type coverage;
3. Group coverage through closed panel plans;
4. Group-type contracts;
5. The medical care components of long-term care contracts, such as skilled nursing care;
6. Medicare or other governmental benefits, as permitted by law, except as provided in Paragraph (4) (h) of this section. That part of the definition of plan may be limited to the *hospital*, medical and surgical benefits of the governmental program; and
7. Group and nongroup insurance contracts and *subscriber* contracts that pay or reimburse for the cost of dental care.
8. Nongroup insurance contracts issued on or after January 1, 2014.
9. Nongroup coverage through closed panel plans issued on or after January 1, 2014.

Plan does not include:

1. *Hospital* indemnity coverage benefits or other fixed indemnity coverage;
2. Accident only coverage;
3. Specified disease or specified accident coverage;
4. Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, *respite care* and *custodial care* or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
5. Medicare supplement policies;
6. A state plan under Medicaid; or
7. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

2) This plan means, in a COB provision, the part of the *contract* providing the health care benefits

to which the COB provision applies and which may be reduced because of the benefits of *other plans*. Any other part of the *contract* providing health care benefits is separate from this plan. A *contract* may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

3) The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.

   When this plan is primary, it determines payment for its benefits first before those of any *other plan* without considering any *other plan's* benefits. When this plan is secondary, it determines its benefits after those of *another plan* and may reduce the benefits it pays so that all plan benefits do not exceed 100 percent of the total allowable expense.

4) Allowable expense is a health care expense, including *deductibles*, *coinsurance* and *copayment*s, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a *provider* by law or in accordance with a contractual agreement is prohibited from charging a *member* is not an allowable expense.

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

a) The difference between the cost of a semi-private *hospital* room and a private *hospital* room is not an allowable expense, unless one of the plans provides coverage for private *hospital* room expenses.
b) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

c) The amount of any benefit reduction by the primary plan because a *member* has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

5) Closed panel plan is a plan that provides health care benefits to *member*s primarily in the form of services through a panel of *provider*s that have contracted with or are employed by the plan, and that excludes coverage for services provided by other *provider*s, except in cases of *emergency* or referral by a panel member.

6) Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the *calendar year* excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. The primary plan pays or provides its benefits according to its terms of coverage and

without regard to the benefits of under any *other plan*.

B. (1) Except as provided in Paragraph B (2) a plan that does not contain a coordination of benefits provision that is consistent with K.A.R. 40-4-34 is always primary unless the provisions of both plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the *contract* holder. These types of situations include major medical coverages that are superimposed over base plan *hospital* and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-*network* benefits.

C. A plan may consider the benefits paid or provided by *another plan* in calculating payment of its benefits only when it is secondary to that *other plan*.

D. Each plan determines its order of benefits using the first of the following rules that apply:

(1) Non-*dependent* or *dependent*. The plan that covers the person other than as a *dependent*, for example as an employee, *member*, policyholder, *subscriber* or retiree is the primary plan and the plan that covers the person as a *dependent* is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a *dependent*; and primary to the plan covering the person as other than a *dependent* (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the plan covering the person as an employee, *member*, policyholder, *subscriber* or retiree is the Secondary plan and the *other plan* is the primary plan.

(2) *Dependent* child covered under more than one plan. Unless there is a court decree stating otherwise, when a *dependent* child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a *dependent* child whose parents are married or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the *calendar year* is the Primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(b) For a *dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the *dependent* child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility

has no health care coverage for the *dependent* child's health care expenses, but that parent's *spouse* does, that parent's *spouse's* plan is the primary plan. This rule applies to plan years commencing after the plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the *dependent* child's health care expenses or health care coverage, the provisions of Paragraph D (2)(a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the *dependent* child, the provisions of subparagraph D(2)(a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the *dependent* child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a. The plan covering the custodial parent;

b. The plan covering the *spouse* of the custodial parent;

c. The plan covering the non-custodial parent; and then

d. The plan covering the *spouse* of the non-custodial parent.

(c) For a *dependent* child covered under more than one plan of individuals who are the parents of the child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(i) For a *dependent* child who has coverage under either or both parents' plans and also has his or her own coverage as a *dependent* under a *spouse's* plan, the rule in subsection D(5) within this section applies.

(ii) In the event the *dependent* child's coverage under the *spouse's* plan began on the same date as the *dependent* child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subsection D(2)(a) to the *dependent* child's parent(s) and the *dependent's spouse*.

(3) Active Employee or Retired or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a *dependent* of an active employee and that same person is a *dependent* of a retired or laid-off employee. If the *other plan* does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, *member*, *subscriber* or retiree or covering the person as a *dependent* of an employee, *member*, *subscriber* or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the *other plan* does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The plan that covered the person as an employee, *member*, policyholder, *subscriber* or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the Primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan *deductible* any amounts it would have credited to its *deductible* in the absence of other health care coverage.

B. If a *member* is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel *provider*, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

C. If this plan is secondary to Medicare, it may reduce its benefits so that the total benefits paid are reduced to Medicare's allowable amount, subject to our plan limits.

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and *other plans*. Sunflower or its designated COB administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and *other plans*

covering the person claiming benefits. Sunflower or its designated COB administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give Sunflower or its designated COB administrator any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this plan. If it does Sunflower or its designated COB administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Sunflower or its designated COB administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made'' means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

The Company has the right and responsibility to correct benefit payment errors as required by K.S.A. 40-2442.

CLAIMS

Notice of Claim
Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any *loss* covered by the *contract*, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the *member* or the beneficiary should be sent to the insurer at Ambetter from Sunflower Health Plan, P.O. Box 5010, Farmington, MO 63640-5010, or to any *authorized* agent of the insurer, with information sufficient to identify the *member*, shall be deemed notice to the insurer.

Claim Forms
Upon receipt of a notice of claim, we will furnish to the *claimant* such forms as are usually furnished by us for filing *proofs of loss*. If such forms are not furnished within 15 days after the giving of such notice you shall be deemed to have complied with the requirements of this *contract* as to *proof of loss* upon submitting, within the time fixed in the *contract* for filing *proofs of loss*, written proof covering the occurrence, the character and the extent of the *loss* for which claim is made.

Proof of Loss
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 after the date of *loss* will not be accepted, unless you or your *dependent member* had no legal capacity to submit such proof during that year.

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

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

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

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

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

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

1. Sign, date and deliver to us *authorization*s to obtain any medical or other information, records or documents we deem relevant from any person or entity;

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

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

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

Timely Payment of Claims
Indemnities payable under this *contract* for any *loss* other than *loss* for which this *contract* provides any periodic payment will be paid immediately upon receipt of due written proof of such *loss*. Subject to due written *proof of loss*, all accrued indemnities for *loss* for which this *contract* provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims
Benefits are paid to the *member* within 30 days after receipt of a clean non-electronic claim or 15 calendar days upon receipt of a clean electronic claim.

If Ambetter from Sunflower Health Plan is denying or pending the claim, Ambetter from Sunflower Health Plan shall have 15 calendar days upon receipt of an electronic claim or 30 days upon receipt of a non-electronic claim to notify the health care *provider* or *member* of the reason for denying or pending the claim and what, if any, additional information is required to adjudicate the claim. Upon Ambetter from Sunflower Health Plan receipt of the requested additional information, Ambetter from Sunflower Health Plan shall adjudicate the claim within 45 calendar days. If the required notice is not provided, the claim shall be treated as a clean claim and shall be adjudicated.

Any claim not paid within the time periods specified shall be deemed overdue. When a claim is overdue, the health care *provider* may notify Ambetter from Sunflower Health Plan in writing of Sunflower Health Plan noncompliance. If we fail to pay the claim within the allotted time, then:

1. The amount of the overdue claim shall include an interest payment of 1.5 percent per month beginning from the date the payment was due; and
2. The health care *provider* may recover from Ambetter from Sunflower Health Plan, upon a judicial finding of bad faith, reasonable attorney's fees for advising and representing a health care *provider* in a successful action against us for payment of the claim.

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to

the estate of the *member*. Any other accrued indemnities unpaid at the *member*'s death, at the option of the insurer, may be paid either to such beneficiary or to such estate. All other indemnities will be payable to the *member*.

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

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

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

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

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

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

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

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

Upon request by the custodial parent, we will:

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

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

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

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

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.

GRIEVANCE AND APPEAL PROCEDURES

INTERNAL PROCEDURES

Applicability/Eligibility
The internal *appeal* and *grievance* procedures apply to any *hospital* or medical policy or certificate.

An eligible appellant/grievant is:
1. A *claimant;*
2. In the event the *claimant* is unable to give consent: a *spouse*, family member, or the treating *provider*.

Claimant means the *member* or *member's authorized representative* who has contacted the plan to file a *grievance* or who has contacted the Kansas Department of Insurance to file an external review.

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

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

Claimants should submit all documentation to us at:

Ambetter from Sunflower Health Plan
Attn: Appeals & Grievances Department
PO Box 10341
Van Nuys, CA 91410

Grievance Timeframes
Within five working days of receipt of a *grievance*, a written acknowledgment to the *claimant* or the *claimant's authorized representative* confirming receipt of the *grievance* will be delivered or deposited in the mail.

Grievances will be promptly investigated, and will be resolved within 20 working days of receipt. The time period for investigation may be extended for a period of an additional 20 working days at

a time. If we make use of such extensions, we must provide the *claimant* or the *claimant's authorized representative*, if applicable, written notification of the following within the first 20 working 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.

Written Grievance Response
Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the *grievance* resolution.

The written decision to the grievant must include:

1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *grievance*;

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

APPEALS
An *appeal* is a request to reconsider a decision about the *claimant's* benefits where either a service or claim has been denied.

Claimants have the right to submit written comments, documents, records, and other information relating to the claim for benefits. *Claimants* have the right to review the claim file and to present evidence and testimony as part of the internal review process. A *claimant* may request an *appeal* within 180 days of the *adverse benefit determination.*

Appeals 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 five business days of receipt of an *appeal*, a written acknowledgment to the *claimant* or the *claimant's authorized representative* confirming receipt of the *appeal* will be delivered or deposited in the mail.

When acknowledging an *appeal* 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 *appeal*; and

3. An *appeal* 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
All *appeals* will be resolved and we will notify the *claimant* in writing with the *appeal* decision within the following timeframes:
1. *Post-service claim*: within 30 days after receipt of the *claimant*'s request for internal *appeal*;
2. *Pre-service claim*: within 15 working days after receipt of the *claimant*'s request for internal *appeal*.

Ambetter from Sunflower Health Plan may extend the resolution timeframe by 20 working days if the following conditions are met:
1. The *member* requests an extension or
2. The *member* voluntarily agrees to extend the *appeal* time frame.

A *claimant* shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *claimant's* claim for benefits. All comments, documents, records and other information submitted by the *claimant* relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal *appeal*.
1. When requested, the *claimant* will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The plan will give the *claimant* 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 *claimant* will have the option of delaying the determination for a reasonable period of time to respond to the new information;
2. When requested, the *claimant* will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer. The plan will give the *claimant* 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.

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 *claimant* and us by telephone, facsimile, or other available similarly expeditious method. The plan will issue an *appeal* resolution letter and notify the *member* or *authorized representative* of the right to access expedited external review from the Kansas Insurance Commissioner.

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

Due to the 72-h*our* resolution timeframe, the standard requirements for notification and acknowledgement do not apply to *expedited appeals*.

Ambetter from Sunflower Health Plan may extend the resolution timeframe by 20 working days if the following conditions are met:
1. The *member* requests an extension; or

2. The *member* voluntarily agrees to extend the *appeal* timeframe.

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

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

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

External Review
An external review decision is binding on us. An external review decision is binding on the *claimant* except to the extent the *claimant* has other remedies available under applicable federal or state law.

We will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility
The External Review procedures apply to any *hospital* or medical policy or certificate.

After exhausting the internal review process, the *claimant* has 120 days to make a written request to the Kansas Insurance Commissioner for external review after the date of receipt of our internal response.

1. The internal *appeal* process must be exhausted before the *claimant* may request an external review unless the *claimant* files a request for an expedited external review at the same time as an internal *expedited 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 at the time the *claimant* receives:
    a. An *adverse benefit determination* if the determination involves a medical condition of the *claimant* for which the timeframe for completion of an internal *expedited appeal* would seriously jeopardize the life or health of the *claimant* or would jeopardize the *claimant's* ability to regain maximum function or would subject the *member* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal, and the *claimant* has filed a request for an internal *expedited appeal*; and
    b. A final internal *adverse benefit determination*, if the *claimant* has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the *claimant* or would jeopardize the *claimant's* ability to regain maximum function or would subject the *member* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal, or if the final internal *adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service for which the *claimant* received *emergency services*, but has not been discharged from a facility; and
3. *Claimants* may request an expedited external review at the same time the internal *expedited appeal* is requested and the Kansas Insurance Commissioner will determine if the internal *expedited appeal* needs to be completed before proceeding with the expedited external review.

External review is available for *appeals* that involve:

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

External Review Process

1. The Kansas Insurance Commissioner has ten business days (immediately for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether:
    a. The individual was a *member* at the time the item or service was requested;
    b. The service is a *covered service* under the *claimant's* health plan but for the plan's *adverse benefit determination* with regard to *medical necessity experimental/investigational*, medical judgment, or *rescission*;

c. The *claimant* has exhausted the internal process; and
d. The *claimant* has provided all of the information required to process an external review.

2. Within ten business days (immediately for expedited) after receiving the request for external review, the Kansas Insurance Commissioner will notify the *claimant* in writing as to whether the request is complete and accepted, complete but not eligible for external review and the reasons for its ineligibility or, if the request is not complete, the additional information needed to make the request complete.
3. The Kansas Insurance Commissioner will assign an Independent Review Organization (IRO) to conduct the external review;
4. Within seven business days after the date of assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO.
   Note: For expedited, after assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method;
5. If we fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the *adverse benefit determination*;
6. The Kansas Insurance Commissioner will timely notify the *claimant* in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the *claimant* may submit in writing additional information to the IRO to consider, along with the name, address, and telephone number of the assigned IRO;
7. Upon receipt of any information submitted by the *claimant*, the IRO must forward the information to us within one business day;
8. Upon receipt of the information, we may reconsider our determination. If we reverse our *adverse benefit determination*, we must provide written notice of the decision to the *claimant,* the Kansas Insurance Commissioner, and the IRO immediately after making such decision. The external review would be considered terminated;
9. Within 30 business days (not more than 72 hours for expedited) after the date of receipt of the request for an external review, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to the *claimant,* the Kansas Insurance Commissioner, and to us. If the notice for an expedited review is not in writing, the IRO must provide written confirmation within two days after the date of providing the notice;
10. Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, we will approve the *covered service* that was the subject of the *adverse benefit determination*.

Requests for an External Review should be submitted to:

Kansas Insurance Department
1300 SW Arrowhead Rd.
Topeka, KS 66604
(785) 296-7829 or (800) 432-2484
Website: https://insurance.kansas.gov/complaint/
or email: kid.webcomplaints@ks.gov

Appeals and Grievances Filing and Key Communication Timelines

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard Grievance	N/A	5 Working Days	20 Working Days	20 Working Days
Standard Pre-Service Appeal	180 Calendar Days	5 Working Days	15 Working Days	20 Working Days
Expedited Pre-Service Appeal	180 Calendar Days	N/A	72 Hours	20 Working Days
Standard Post-Service Appeal	180 Calendar Days	5 Working Days	30 Days	20 Working Days
External Review	120 Calendar Days	N/A	30 Calendar Days	N/A
Expedited External Review	120 Calendar Days	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 misrepresentation of fact made regarding a *member* during the application process that relates to insurability will be used to void/rescind the insurance coverage or deny a claim unless:

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

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

Time Limit on Certain Defenses
After two years from the date of issue of this *contract* no misstatements, except fraudulent misstatement, made by the applicant in the application for such *contract* shall be used to void the *contract* or to deny a claim for *loss* incurred or disability commencing after the expiration of such two-year period.

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

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

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

We protect all oral, written and electronic PHI. We follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. We are required to notify you about these practices every year. This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. If you need more information or would like the complete notice, please visit https://ambetter.sunflowerhealthplan.com/privacy-practices.html or call Member Services at 1-844-518-9505 (TTY 1-844-546-9713).

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

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

Statement of Non-Discrimination

Ambetter from Sunflower Health Plan 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 from Sunflower Health Plan insured by Celtic Insurance Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Sunflower Health Plan 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 from Sunflower Health Plan insured by Celtic Insurance Company at 1-844-518-9505 (TTY 1-844-546-9713).

If you believe that Ambetter from Sunflower Health Plan 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 from Sunflower Health Plan insured by Celtic Insurance Company Appeals Unit, PO Box 10341, Van Nuys CA 91410, 1-844-518-9505 (TTY 1-844-546-9713), Fax, 1-844-680-5805. You can file a *grievance* by mail, fax, or email. If you need help filing a *grievance*, Ambetter from Sunflower Health Plan 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.*

Declaración de no discriminación

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

Ambetter de Sunflower Health Plan:

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

Si necesita estos servicios, comuníquese con Ambetter de Sunflower Health Plan a 1-844-518-9505 (TTY 1-844-546-9713).

Si considera que Ambetter de Sunflower Health Plan no le ha proporcionado estos servicios, o en cierto modo le ha discriminado debido a su raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja ante: Ambetter de Sunflower Health Plan Appeals Unit, PO Box 10341, Van Nuys CA 91410, 1-844-518-9505 (TTY 1-844-546-9713), Fax, 1-844-680-5805. Usted puede presentar una queja por correo, fax, o correo electrónico. Si necesita ayuda para presentar una queja, Ambetter from Sunflower Health Plan está disponible para brindarle ayuda. También puede presentar una queja de violación a sus derechos civiles ante la Oficina de derechos civiles del Departamento de Salud y Servicios Humanos de Estados Unidos (U.S. Department of Health and Human Services), en forma electrónica a través del portal de quejas de la Oficina de derechos civiles, disponible en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* o por correo o vía telefónica llamando al: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TTY).

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

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Sunflower Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-518-9505 (TTY 1-844-546-9713).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Sunflower Health Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-518-9505 (TTY 1-844-546-9713).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Sunflower Health Plan 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與 一位翻譯員講話，請撥電話 1-844-518-9505 (TTY 1-844-546-9713)。
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Sunflower Health Plan hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-518-9505 (TTY 1-844-546-9713) an.
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Sunflower Health Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-518-9505 (TTY 1-844-546-9713) 로 전화하십시오.
Laotian:	ຖ້າທ່ານ ຫຼື ບຸກຄົນ ທ່ານກຳລັງ ຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ Ambetter from Sunflower Health Plan, ທ່ານມີສິດ ທີ່ຈະໄດ້ ຮັບການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ຂໍ້ມູນຂ່າວສານ ທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ເສຍຄ່າ. ເພື່ອ ລົມກັບ ນາຍພາສາ ໃຫ້ ໂທຫາ 1-844-518-9505 (TTY 1-844-546-9713).
Arabic:	إذا كان لديك أو لدى شخص أنت تساعده أسئلة حول Ambetter from Sunflower Health Plan ، لديك الحق في الحصول على المعلومات الضرورية والمعلومات بلغتك دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-844-518-9505 (TTY 1-844-546-9713) .
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Sunflower Health Plan, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-518-9505 (TTY 1-844-546-9713).
Burmese:	သင့် သို့မဟုတ် သင်ကူညီပေးသူတစ်ဦးဦးတွင် Ambetter from Sunflower Health Plan အကြောင်း မေးစရာမေးခွန်းများရှိပါမှက အခမဲ့အကူအညီ ရယူရှိခွင့်များသင့်တွင် သင့်၏ဘာသာစကားဖြင့် အခြားသူများကဲ့သို့ အခမဲ့ရယူရှိခွင့် ရှိပါသည်။ စကားပြန်တစ်ဦးဦးနှင့် စကားပြောဆိုရန် 1-844-518-9505 (TTY 1-844-546-9713) ကို ဖုန်းဆက်ပါ။
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Sunflower Health Plan, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-844-518-9505 (TTY 1-844-546-9713).
Japanese:	Ambetter from Sunflower Health Plan について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-844-518-9505 (TTY 1-844-546-9713) までお電話ください。
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Sunflower Health Plan вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-844-518-9505 (TTY 1-844-546-9713).
Hmong:	Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Ambetter from Sunflower Health Plan, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-844-518-9505 (TTY 1- 844-546-9713).
Persian:	اگر شما، يا کسي که به او کمک مي کنيد سؤالي در مورد Ambetter from Sunflower Health Plan داريد، از اين حق برخورداريد که کمک و اطلاعات را بصورت رايگان به زبان خود دريافت کنيد. براي صحبت کردن با مترجم با شماره 1-844-518-9505 (TTY 1-844-546-9713) تماس بگيريد.
Swahili:	Ikiwa wewe au mtu mwingine unayemsaidia, ana maswali kuhusu Ambetter from Sunflower Health Plan, una haki ya kupata usaidizi na taarifa kwa lugha yako bila malipo. Ili kuzungumza na mkalimani, piga simu 1-844-518-9505 (TTY 1-844-546-9713).

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