ambetter. of Oklahoma

2023 Evidence of Coverage

AmbetterofOklahoma.com

62505OK012-2023

AMBETTER OF OKLAHOMA

Home Office: 14000 Quail Springs Parkway, Suite 650, Oklahoma City, OK 73134

Major Medical Expense Insurance Policy

In this *policy,* the terms "you" and ”your” will refer to the *covered person* or any *dependents* enrolled in this *policy.* The terms ”we,” ”our” or ”us” will refer to Ambetter of Oklahoma.

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

Guaranteed renewable means that this *policy* will renew each year on the anniversary date unless terminated earlier in accordance with *policy* terms. You may keep this *policy* in force by timely payment of the required premiums. However, we may decide not to renew the policy as of the renewal date if: (1) we decide not to renew all policies issued on this form, with the same 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 *policy* benefits.

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

At least 45 days’ notice of any plan to take an action or make a change permitted by this clause will be delivered to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under this *policy* or a change in a *member's* health. While this *policy* is in force, we will not restrict coverage already in force. If we discontinue offering and decide not to renew all polices issued on this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 90 days prior to the date that we discontinue coverage.

This *policy* contains *prior authorization* requirements. Benefits may be reduced or not covered if the requirements are not met. Please refer to the *Schedule of Benefits* and the *Prior Authorization* section.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony

TEN DAY RIGHT TO RETURN POLICY

Please read your *policy* carefully. If you are not satisfied, return this *policy* to us or to our agent within ten days after you receive it. All premiums paid will be refunded, less claims paid, and the *policy* will be considered null and void from the *effective date*. If we do not refund the premiums paid within 30 days of the cancellation request, we will pay interest on those proceeds as required by state law.

Ambetter of Oklahoma

Kevin J. Counihan
President

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SPECIAL NOTICE OF PROTECTION PROVIDED BY
OKLAHOMA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

THIS NOTICE PROVIDES A BRIEF SUMMARY OF THE OKLAHOMA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ("THE ASSOCIATION") AND THE PROTECTION IT PROVIDES FOR POLICYHOLDERS. THIS SAFETY NET WAS CREATED UNDER OKLAHOMA LAW, WHICH DETERMINES WHO AND WHAT IS COVERED AND THE AMOUNTS OF COVERAGE. THE ASSOCIATION WAS ESTABLISHED TO PROVIDE PROTECTION IN THE UNLIKELY EVENT THAT YOUR LIFE, ANNUITY OR HEALTH INSURANCE COMPANY BECOMES FINANCIALLY UNABLE TO MEET ITS OBLIGATIONS AND IS TAKEN OVER BY ITS INSURANCE DEPARTMENT. IF THIS SHOULD HAPPEN, THE ASSOCIATION WILL TYPICALLY ARRANGE TO CONTINUE COVERAGE AND PAY CLAIMS, IN ACCORDANCE WITH OKLAHOMA LAW, WITH FUNDING FROM ASSESSMENTS PAID BY OTHER INSURANCE COMPANIES.

THE BASIC PROTECTIONS PROVIDED BY THE ASSOCIATION ARE:
• LIFE INSURANCE
• $300,000 IN DEATH BENEFITS
• $100,000 IN CASH SURRENDER OR WITHDRAWAL VALUES

• HEALTH INSURANCE
• $500,000 IN HOSPITAL, MEDICAL AND SURGICAL INSURANCE BENEFITS
• $300,000 IN DISABILITY INCOME INSURANCE BENEFITS
• $300,000 IN LONG-TERM CARE INSURANCE BENEFITS
• $100,000 IN OTHER TYPES OF HEALTH INSURANCE BENEFITS
• ANNUITIES
• $300,000 IN WITHDRAWAL AND CASH VALUES

THE MAXIMUM AMOUNT OF PROTECTION FOR EACH INDIVIDUAL, REGARDLESS OF THE NUMBER OF POLICIES OR CONTRACTS, IS $300,000, EXCEPT THAT WITH REGARD TO HOSPITAL, MEDICAL AND SURGICAL INSURANCE BENEFITS, THE MAXIMUM AMOUNT THAT WILL BE PAID IS $500,000.

NOTE: CERTAIN POLICIES AND CONTRACTS MAY NOT BE COVERED OR FULLY COVERED. FOR EXAMPLE, COVERAGE DOES NOT EXTEND TO ANY PORTION(S) OF A POLICY OR CONTRACT THAT THE INSURER DOES NOT GUARANTEE, SUCH AS CERTAIN INVESTMENT ADDITIONS TO THE ACCOUNT VALUE OF A VARIABLE LIFE INSURANCE POLICY OR A VARIABLE ANNUITY CONTRACT. THERE ARE ALSO VARIOUS RESIDENCY REQUIREMENTS AND OTHER LIMITATIONS UNDER OKLAHOMA LAW.

TO LEARN MORE ABOUT THE ABOVE PROTECTIONS, PLEASE VISIT THE ASSOCIATION'S WEBSITE AT WWW.OKLIFEGA.ORG, OR CONTACT: OKLAHOMA LIFE & HEALTH INSURANCE GUARANTY ASSOCIATION 201 ROBERT S. KERR, SUITE 600 OKLAHOMA CITY, OK 73102 PHONE (405) 272-9221

OKLAHOMA DEPARTMENT OF INSURANCE 400 NE 50TH STREET OKLAHOMA CITY, OK 73105 1-800-522-0071 OR (405) 521-2828

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INTRODUCTION

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

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

This *policy,* the *Schedule of Benefits*, and the enrollment application, including 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 *policy* to gain a full understanding of your coverage. Many words used in this *policy* have special meanings when used in a health care setting. These words are *italicized* and are defined in the Definitions section. This *policy* also contains exclusions, so please be sure to read this entire *policy* carefully.

How to Contact Us
Ambetter of Oklahoma
14000 Quail Springs Parkway, Suite 650
Oklahoma City, OK 73134

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. CST
Member Services **1-833-492-0679**
TTY line **711**
Fax **1-833-959-3364**
Emergency **911**
24/7 Nurse Advice Line **1-833-492-0679** or for the hard of hearing **TTY 711**

Interpreter Services
Ambetter of Oklahoma 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 medical interpreters to assist with other languages. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpreter services, please call Member Services at 1-833-492-0679 or for the hard of hearing TTY 711.

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

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

You have the right to:

1. Participate with your *physician* and *medical practitioners* in making 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 who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which you have coverage.
4. Be treated with respect and dignity.
5. Privacy of your personal health information, consistent with state and federal laws, and our policies.
6. Receive information or make recommendations, including changes, about our organization and services, our *network* of *physicians*, *medical practitioners*, *hospitals,* other facilities and your rights and responsibilities.
7. 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 *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* can tell you about treatments that may or may not be covered by the *policy*, 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, *primary care physician* 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, 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 *primary care physician*'s instructions are not followed. You should discuss all concerns about treatment with your *primary care physician*. Your *primary care physician* can discuss different treatment plans with you, if there is more than one option that may help you. You will make the final decision.
17. Select your *primary care physician* within the *network*. You also have the right to change your *primary care physician* 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 *primary care physician*.
19. An interpreter when you do not speak or understand the language of the area.
20. A second opinion by a *network physician*, 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. Advance directives are forms you can complete to protect your rights for medical care. It can help your *primary care physician* 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. *Members* also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive. Examples of advance directives include:
    a. Living Will;
    b. Health Care Power of Attorney; or
    c. "Do Not Resuscitate" Orders.

You have the responsibility to:

1. Read this *policy* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about your health that we or your *medical practitioners* need in order to provide care. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your *physician* until you understand the care you are receiving.
4. Review and understand the information you receive about us. You need to know the proper use of *covered services*.
5. Show your *member* identification card and keep scheduled appointments with your *physician*, and call the *physician's* office during office hours whenever possible if you have a delay or cancellation.
6. Know the name of your assigned *primary care physician*. You should establish a relationship with your *physician*. You may change your *primary care physician* verbally or in writing by contacting Member Services.

7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
8. Understand your health problems and participate, along with your health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Follow the treatment plans and instructions for care that you have agreed on with your health care professionals and *physician*.
10. 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 *primary care physician* 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.
11. Follow all health benefit plan guidelines, provisions, policies, and procedures.
12. Use any *emergency* room only when you think you have a medical *emergency*. For all other care, you should call your *primary care physician*.
13. When you enroll in this coverage, give all information about any other medical coverage you have. If, at any time, you get other medical coverage besides this coverage, you must tell us.
14. Pay your monthly premium, *deductible amount, copayment amounts*, and *coinsurance amounts* on time.
15. Notify us, or the entity in which you enrolled, of any enrollment related changes that would affect your *policy* within 60 days of the event. Enrollment related changes include the following: birth of a child, adoption, marriage, divorce, change of address, adding/removing a *dependent*, *spouse*/domestic partner becomes eligible under a different insurer, or incarceration where *member cost share* would need to transfer from one *policy* to another *policy*.

IMPORTANT INFORMATION

Provider Directory
A listing of *network providers* is available online at ambetterofoklahoma.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 selecting 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 1-833-492-0679 (TTY: 711). In order to obtain benefits, you must designate a *primary care physician ("PCP")* for each *member.* We can help you pick a *PCP*. We can make your choice of *PCP* effective on the next business day.

Call the *PCP's* office if you want to make an appointment. If you need help, call Member Services at 1-833-492-0679 (TTY: 711). We will help you make the appointment.

Member Identification Card
We will mail you a *member* identification card after we receive your completed enrollment materials, and you have paid your initial premium payment. This card is proof that you are enrolled in an Ambetter plan. You need to keep this card with you at all times. Please show this card every time you go for any service under the *policy*. The *member* identification card will show your name, *member* identification number, the phone numbers for Member Services, pharmacy, and 24/7 Nurse Advice Line, 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 1-833-492-0679. We will send you another card. A temporary member identification card can be downloaded from our secure member portal at ambetterofoklahoma.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 ambetterofoklahoma.com. It also gives you information on your benefits and services such as:

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

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

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

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

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

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

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

Please review the Access to Care and Major Medical Expense Benefit sections of this *policy* for detailed information.

DEFINITIONS

In this *policy*, italicized words are defined. Words not italicized will be given their ordinary meaning.

Wherever used in this *policy*:

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 is *rehabilitation* for patients who will benefit from an intensive, multidisciplinary *rehabilitation* program. Patients normally receive a combination of therapies such as physical, occupational and speech therapy as needed and are medically managed by specially trained *physicians*. *Rehabilitation services* must be performed for three or more hours per day, five (5) to seven (7) days per week, while the *covered person* is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *skilled nursing facility*.

Advance premium tax credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Marketplace. Advance payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit payments to apply to your premiums each month, up to the maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you 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 a determination by us that an admission, availability of care, continued stay or other health care service that is a *covered service* has been reviewed and, based upon the information provided, does not meet our requirements for *medical necessity*, appropriateness, health care setting, level of care, effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

Refer to the Grievance and Complaint Procedures section of this *policy* for information on your right to *appeal* an *adverse benefit determination*.

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

Please note, if you receive services from a *non-network provider*, you may be responsible for the difference between the amount the provider charges for the service (*billed amount*) and the *allowed amount* that we pay. However, you will not be responsible for *balance billing* for unanticipated out-of-network care that is otherwise covered under your plan and that is provided by a *non-network provider* at a *network* facility, unless you gave informed consent before receiving 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 ambetterofoklahoma.com/health-plans/our-benefits/ambetter-telehealth.html.

Appeal means a request by the *member* or their *authorized representative* to reverse, rescind, or otherwise modify an *Adverse Benefit Determination*.

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

Applied behavior analysis (ABA) is the design, implementation, and evaluation of environmental modifications by a board-certified behavior analyst 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.

Authorization or ***authorized*** means our decision to approve the *medically necessity* or the appropriateness of care for a *member* by the *member's PCP* or provider group. *Authorizations* are not a guarantee of payment.

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

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

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

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

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

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

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

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

Care management means a program in which a registered nurse or licensed mental health professional, known as a case 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*.

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*.

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

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

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from *pregnancy*, but are adversely affected by *pregnancy* or are caused by *pregnancy* and not, from a medical viewpoint, associated with a normal *pregnancy*. This includes: ectopic *pregnancy*, spontaneous *abortion*, eclampsia, missed *abortion*, and similar medical and surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, *physician* prescribed rest during the period of *pregnancy*, morning sickness, and conditions of comparable severity associated with management of a difficult *pregnancy*, and not constituting a medically classifiable distinct *complications of pregnancy*; 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 *serio*us *and complex condition* from that provider or facility; (ii) is undergoing a course of institutional or inpatient care from that provider or facility; (iii) is scheduled to undergo non-elective *surgery* from that provider, including postoperative care; (iv) is pregnant and undergoing a course of treatment for the pregnancy; or (v) is determined to be *terminally ill* and is receiving treatment for such *illness*.

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

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

Cost sharing means the *deductible amount*, *copayment amount* and *coinsurance* that you pay for *covered services*. The *cost sharing* amount that you are required to pay for each type of *covered service* is listed in the *Schedule of Benefits*. When you receive *covered services* from a *non-network provider* in a *network* facility, or

when you receive *covered emergency services* or air ambulance services from *non-network providers*, *cost sharing* may be based on an amount different from the *allowed amount.*

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

Covered expense or ***covered service*** means an expense or service that is:

1. Incurred while your or your *dependent's* insurance is in force under this *policy*;
2. Covered by a specific benefit provision of this *policy*; and
3. Not excluded anywhere in this *policy*.

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

Custodial care includes but is not limited to the following:

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

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 the *Schedule of Benefits*.

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

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

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

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

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

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 *policy* for *covered services*.

Eligible child means the child of the 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 foster child placed in your custody;
4. A child placed with you for adoption;
5. A child for whom legal guardianship has been awarded to you, your *spouse,* or domestic partner; or
6. A stepchild.

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

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

1. For *network providers*: When a *covered expense* is received from a *network provider*, the *eligible service expense* is the contracted fee with that provider.
2. For *non-network providers*, unless otherwise required by federal or Oklahoma law, the *eligible service expense* is as follows:
    a. When a *covered emergency service* or *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 will not be *balance billed* for the difference between the amount we pay and the provider's charges, but you may be subject to *cost sharing* obligations. If you are *balance billed* in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.

    b. When a *covered service* is received from a *non-network* professional provider who renders non-*emergency services* at a *network* facility, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the *provider* as payment in full. 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. Unless you receive and sign the necessary written notice and consent document under federal law before the services are provided, you will not be *balance billed* for the difference between the amount we pay and the provider's charges, but you may be subject to *cost sharing* obligations. *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. 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.

d. Except as provided under (2)(a) and (2)(b) above, when a *covered expense* is received from a *non-network provider*, the *eligible service expense* is determined based on the lowest amount of the following:
    i. the negotiated fee that has been agreed upon by us and the provider;
    ii. 100 percent of the fee Medicare allows for the same or similar services provided in the same geographical area;
    iii. the fee established by us by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by us;
    iv. the fee charged by the provider for the services; or
    v. a fee schedule that we develop.

    You may be billed for the difference between the amount paid and the provider's charge.

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

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

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

Follow-up care is not considered emergency care. Benefits are provided for treatment of *emergency* medical conditions and *emergency* screening and stabilization services without *prior authorization*. Benefits for *emergency* care include facility costs and *physician* services, and supplies and *prescription drugs* charged by that facility. You must notify us or verify that your *physician* has notified us of your admission to a *hospital* within 48 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the *inpatient* setting is appropriate, and if appropriate, the number of days considered *medically necessary*. By contacting us, you may avoid financial responsibility for any

inpatient care that is determined to be not *medically necessary* under your *policy*. If your provider does not contract with us, you will be financially responsible for any care we determine is not *medically necessary*. Care and treatment provided once you are *medically stabilized* is no longer considered *emergency* care. Continuation of care from a *non-network provider* beyond what is needed to evaluate or stabilize your condition in an *emergency* will be covered as a non-*network* service unless we *authorize* the continuation of care and it is *medically necessary*.

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

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

Experimental or ***investigational*** 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 *covered person.*
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. . Benefits are available for routine care costs that are incurred in the course of a clinical trial if the services provided are otherwise *covered services* under this *policy*.

Extended care facility means an institution, or a distinct part of an institution, that:

1. Is licensed as a *hospital*, *extended care facility*, or *rehabilitation facility* by the state in which it operates;
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *physician* and the direct supervision of a registered nurse;
3. Maintains a daily record on each patient;
4. Has an effective *utilization review* plan;
5. Provides each patient with a planned program of observation prescribed by a *physician;* and
6. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing *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, custodial care,* nursing care, or for care of *mental 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 *policy*. The decision to apply *physician* specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by us.

Grievance means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing in any form to the insurer by, or on behalf of, a claimant including any of the following:
1. Provision of services;
2. Determination to rescind a *policy*;
3. Determination of a diagnosis or level of service required for evidence-based treatment of *autism spectrum disorders*; and
4. Claims practices.

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

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 *covered person.*

Home health care means care or treatment of an *illness* or *injury* at the *covered person's* home that is:
1. Provided by a *home health care agency*; and
2. Prescribed and supervised by a *physician*.

Home health care agency means a public or private agency, or one of its subdivisions, that:
1. Operates pursuant to law as a *home health care agency*;
2. Is regularly engaged in providing *home health care* under the regular supervision of a registered nurse;
3. Maintains a daily medical record on each patient; and

4. Provides each patient with a planned program of observation and treatment by a *physician,* in accordance with existing *generally accepted standards of medical practice* for the *injury* or *illness* requiring the *home health care.*

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

Hospice means services designed for and provided to *members* who are not expected to live for more than 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 a *terminally ill covered person* and those of the *covered person's immediate family.*

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

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *skilled nursing 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 *covered person* will be deemed not to be confined in a *hospital* for purposes of this *policy*.

Illness means a sickness, disease, or disorder of a *covered person*.

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

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

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

Intensive day rehabilitation means two or more different types of therapy provided by one or more *rehabilitation licensed practitioners* and performed for three (3) or more hours per day, five (5) to seven (7) days per week.

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

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

Maximum out-of-pocket amount means the sum of the *deductible amount*, *prescription drug deductible amount* (if applicable), *copayment amount* and *coinsurance amount* of *covered services*, as shown in the *Schedule of Benefits*. **Note:** There are separate *maximum out-of-pocket* amounts for *network* benefits versus non-network benefits.

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

Medical practitioner includes, but is not limited to, a *physician*, nurse anesthetist, physician's assistant, physical therapist, licensed mental health and *substance use* practitioners, nurse practitioners, audiologists, chiropractors, dentists, pharmacists, nurse anesthetists, optometrists, podiatrists, psychologists or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* acupuncturist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, *emergency* medical technician, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *covered person*, 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, item, supply or treatment *authorized* by a provider to diagnose and treat a *covered person*'s *illness or injury* which:

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

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

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

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

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

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

Necessary medical supplies mean medical supplies that are:

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

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

Network means a group of *medical practitioners* and providers who have contracts that include an agreed upon price for health care expenses.

Network eligible service expense means a group of providers or facilities, including but not limited to, *hospitals, inpatient* mental healthcare facilities, medical clinics, *behavioral health* clinics, acupuncturists, chiropractors, massage therapists, nurse practitioners, addiction medicine practitioners, etc., who have contracts with us, or our contractor or subcontractor, and have agreed to provide 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 provider means any licensed person or entity that has entered into a contract with Ambetter of Oklahoma to provide covered services to *members* enrolled under this *policy*, including but not limited to, hospitals, specialty hospitals, urgent care facilities, *physicians*, pharmacies, laboratories and other health professionals within our *service area*.

Non-elective 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 contracted with the plan as a *network provider*. Services received from a *non-network provider* are covered at a reduced amount from those services received from a *network provider*. Please refer to your *Schedule of Benefits*.

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. *Orthotic devices* must be used for therapeutic support, protection, restoration or function of an impaired body part for treatment of an *illness* or *injury*.

Other plan means any plan or *policy* that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, automobile no-fault or medical pay, homeowner insurance medical pay, premises medical pay, nonprofit health service plans, health maintenance organization subscriber contracts, self-insured group plans, prepayment plans, and Medicare when the *covered person* 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 facility, ancillary, and professional charges when given as an outpatient at a *hospital*, alternative care facility, retail health clinic, or other provider as determined by the plan. These facilities may include a non-*hospital* site providing diagnostic and therapy services, *surgery*, or *rehabilitation*, or other *provider facility* as determined by us. Professional charges only include services billed by a *physician* or other professional.

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

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

Policy means this *policy* issued and delivered to you. It includes the attached pages, the enrollment applications, the *Schedule of Benefits* and any amendments or riders.

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

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

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

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

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

Primary care physician or ***PCP*** means a provider who gives or directs health care services for you. *PCPs* includes a family practitioner, general practitioner, advanced practice registered nurses (APRN), physician assistant (PA), pediatrician, internist, obstetrician, gynecologist, or any other practice allowed under the *policy.* A *PCP* supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Is not a *hospital, skilled nursing 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 *covered person* in order to provide relief to the *covered person's immediate family* or other caregiver.

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

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

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

Service area means a geographical area, made up of counties, where we have been *authorized* by the State of Oklahoma to sell and market our health plans. This is where the majority of our *network providers* are located where you will receive all of your health care services and supplies.

Skilled nursing facility means an institution, or a distinct part of an institution, that:

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

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

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 or ***specialist provider*** means a *physician* 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.

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

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 *covered person's illness* or *injury* by manual or instrumental operations, performed by a provider while the *covered person is under general or local anesthesia.*

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

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

Synchronization means the coordination of medication refills for a patient taking two or more medications for one or more chronic conditions such that the patient's medications are refilled on the same schedule for a given time period.

Telehealth or ***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 *covered person* has six (6) months or less to live.

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

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

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

Unproven service(s) means services, including medications, that are determined not to be effective for treatment of the medical condition, or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from w*ell-conducted randomized controlled trials* or w*ell-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 *covered person's* health; and
2. As a result of an unforeseen *illness, injury,* or the onset of acute or severe symptoms.

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

DEPENDENT MEMBER COVERAGE

Dependent Eligibility
Your *dependents* become eligible for insurance on the latter of:

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

Effective Date for Initial Dependent Members
Dependent members included in the initial enrollment application for this *policy* 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. Each type of *covered service* incurred by the newborn child will be subject to the *cost sharing* amount listed in the S*chedule of Benefits*.

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

Coverage for an Adopted Child
An adopted child of a *covered person* shall be covered from the date of the filing of a petition for adoption if (1) the *covered person* applies for coverage within 60 days after the filing of the petition for adoption and where the issuer is notified by the Marketplace and (2) premium billed for this 60-day period is timely paid under the terms of this *policy* and its grace period after such application. However, the coverage shall begin from the moment of birth if (1) the petition for adoption and application for coverage is filed within 60 days after the birth of the child, and (2) premium billed for this 60-day period is timely paid under the terms of this *policy* and its grace period after such application. The child will be covered for *loss* due to *injury* and *illness*, including *medically necessary* care and treatment of conditions existing prior to the date of *placement.*

Unless an enrollment application is received within 60 days of petition of adoption, and premium is timely paid for the first 60 days under the terms of this *policy* and its grace period, coverage for the adopted child will not be effective and the adopted child cannot be enrolled until the next open enrollment period. Coverage for an adopted child shall terminate upon the dismissal or denial of a petition for adoption.

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

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

Adding Other Dependent Members
If you are enrolled in an off-exchange *policy* and apply in writing, or directly at enroll.ambetterhealth.com, to add a *dependent* and you pay the required premiums, we will send you written confirmation of the added *dependent's effective date* of coverage and *member* identification cards for the added *dependent.*

ONGOING ELIGIBILITY

For All Covered Persons
A *covered person's* eligibility for insurance under this *policy* will cease on the earlier of:

1. The date that a *covered person* is no longer within the Grace Period based on a failure to make timely payment. See the Grace Period provision for additional details; or
2. The *subscriber* residing outside the *service area* or moving permanently outside the *service area* of this *policy*; or
3. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or
4. The date of termination that the Marketplace provides us upon your request of cancellation to the 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; or
5. The date we decline to renew this *policy,* as stated in the Discontinuance provision; or
6. The date of *a covered person's* death; or
7. The date a *covered person's* eligibility for insurance under this *policy* ceases due to losing *network* access as the result of a permanent move.

If you have material modifications (examples include a change in life event such as marriage, death or other change in family status), or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Marketplace) at www.healthcare.gov or 1-800-318-2596.

For Dependent Members
A *dependent* will cease to be a *covered person* at the end of the premium period in which the *covered person* ceases to be your *dependent* due to divorce or if a child ceases to be an *eligible child*. For *eligible children*, the Marketplace will send a termination letter with an *effective date* the last day of the *dependent's* 26th birth month.

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

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

The policyholder must provide notification and proof of the incapacity or dependency to us at our request and expense.

There is no time limit for the policyholder to provide notification that their incapacitated *dependent* has reached the age limit.

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

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

1. A *qualified individual* or *dependent loses minimum essential coverage*, non-calendar year group or individual health insurance coverage, *pregnancy*-related coverage, access to health care services through coverage provided to a pregnant enrollee's unborn child, or medically needed coverage;
2. A *qualified individual* gains a *dependent* or becomes a *dependent* through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order. In the case of marriage, at least one *spouse* must demonstrate having minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage;
3. A *qualified individual* or *dependent*, who was not previously a citizen, national, or lawfully present individual gains such status; or who is no longer incarcerated or whose incarceration is pending the disposition of charges;
4. A *qualified individual's* enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or its instrumentalities as evaluated and are determined by the Health Insurance Marketplace;
5. An enrollee or *dependent* adequately demonstrates to the Health Insurance Marketplace that the plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
6. A *qualified individual*, enrollee, or *dependent*, adequately demonstrates to the Health Insurance Marketplace that a material error related to plan benefits, *service area*, or premium influenced the qualified individual's or enrollee's decision to purchase the qualified health plan (*QHP)*;
7. An enrollee or *dependent* enrolled in the same plan is determined newly eligible or newly ineligible for *advance premium tax credits* or has a change in *eligibility* for *cost sharing reductions*;
8. A *qualified individual* or *dependent* who is enrolled in an eligible employer-sponsored plan is determined newly eligible for *advance premium tax credits* based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-2(c)(3);
9. A *qualified individual*, enrollee, or *dependent* gains access to new *QHPs* as a result of a permanent move, and had minimum essential coverage as described in 26 CFR 1.5000A–1(b) for one or more days during the 60 days preceding the date of the permanent move;
10. A *qualified individual* or *dependent* who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a plan or change from one plan to another one time per month;
11. A *qualified individual* or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by Health and Human Services (HHS), that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide;
12. A *qualified individual*, enrollee, or *dependent* is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B–2, and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
13. A *qualified individual* or *dependent* is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 days after the qualifying event; or applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;
14. A *qualified individual* newly gains access to an employer sponsored Individual Coverage

Health Reimbursement Arrangement (ICHRA) (as defined in 45 CFR 146.123(b)) or a Qualified Small Employer Health Reimbursement Arrangement (QSHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code);

15. At the option of the Health Insurance Marketplace, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a plan through the Health Insurance Marketplace following termination of enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence; or
16. A *qualified individual* or *dependent* is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions or government subsidies completely cease.
17. Subject to the availability of enhanced tax subsidies, a *qualified individual* or enrollee, or their *dependent* was eligible for advance payments the premium tax credit, and whose household income is expected to be no greater than 150 percent of the Federal poverty level.

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

If you are currently enrolled in Ambetter of Oklahoma, please contact Member Services at 1-833-492-0679 with any questions related to your health insurance coverage

Coverage Effective Dates for Special Enrollment Periods

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

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

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

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

triggering event. If the plan selection is made after the date of the triggering event, coverage is effective on the first day of the following month.

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

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

Prior Coverage

If a *member* is confined as an *inpatient* in a *hospital* on the *effective date* of this *policy*, and prior coverage terminating immediately before the *effective date* of this *policy* furnishes benefits for the hospitalization after the termination of prior coverage, then services and benefits will not be covered under this *policy* 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 Ambetter allowable and you may be billed for any balance of costs above the Ambetter allowable.

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:

> Premium payments are due in advance, on a calendar month basis. Monthly payments are due before the first day of each month for coverage effective during such month. After the first premium is paid, a 90 day grace period starting from the premium due date is given for the payment of premium. 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. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if *advance premium tax credits* are received.
>
> We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period, and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. We will notify Health and Human Services (HHS) of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the second and third month of the grace period. We will continue to collect *advance premium tax credit*s on behalf of the *member* from the Department of the Treasury, and will return the *advance 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 before the first day of each month for coverage effective during such month. After the first premium is paid, a 60 day grace period starting from the premium due date is given for the payment of premium. 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. Coverage will remain in force during the grace period; however, claims may pend for *covered services* rendered to the *member* during the grace period. We will notify the *member*, as well as providers, of the possibility of denied claims when the *member* is in the grace period.

Third Party Payment of Premiums or Cost Sharing
We require each policyholder to pay his or her premiums and this is communicated on your monthly billing statements. Our payment policies were developed based on guidance from the Centers for Medicare and Medicaid Services (CMS) recommendations against accepting *third party* premiums. Consistent with CMS guidance, the following are the ONLY acceptable third parties who may pay premiums on your behalf:

1. Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
2. Indian tribes, tribal organizations or urban Indian organizations;
3. State and Federal Government programs;
4. Family members;

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.

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

Change or Misstatement of Residence
If you change your *residence*, you must notify the 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 or nicotine question on the enrollment application is material to our correct underwriting. If a *covered person's* us*e of tobacco or nicotine* has been misstated on the *covered person's* enrollment application for coverage under this *policy,* we have the right to rerate the *policy* back to the original *effective date*.

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 *covered person.* However, there are some *network eligible service expenses* for which you must obtain the *prior authorization*.

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

1. Receives a service or supply*;* or
2. Are admitted into a facility*.*

Prior authorization (medical and *behavioral health*) requests must be received by phone/eFax/provider portal as follows:

1. At least five days prior to an elective admission as an *inpatient* in a *hospital*, extended care or *rehabilitation facility*, *hospice, 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 an *inpatient* admission, including emergent *inpatient* admission.
5. At least five days prior to the start of *home health care* except *members* needing *home health care* after *hospital* discharge.

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

1. For urgent concurrent reviews, within 24 hours (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.

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 *covered person.*

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

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

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

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

Denial of Prior Authorization
Refer to the Grievance and Complaint Procedures section of this *policy* for information on your right to *appeal* a denied *authorization*.

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.*

COST SHARING FEATURES

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

When you, or a covered *dependent*, 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 *policy* are adjudicated or processed as we receive them. Coverage is only provided for *eligible service expenses*. Each claim received will be processed separately according to the *cost share* as outlined in this *policy* and in your *Schedule of Benefits*.

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

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

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

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 *member*'s *eligible service expenses*.

A *covered person's maximum out-of-pocket* will not exceed the individual *maximum out-of-pocket* amount.

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

1. You satisfy your individual *maximum out-of-pocket*; or

2. Your family satisfies the family *maximum out-of-pocket* amount for the *calendar year*.

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

The amount payable will be subject to:
1. Any specific benefit limits stated in the *policy*;
2. A determination of *eligible service expenses*; and
3. Any reduction for expenses incurred at a *non-network provider*.

Please refer to the applicable *deductible amount(s), coinsurance amounts,* and *copayment amounts* on your *Schedule of Benefits*.

Non-Network Liability and Balance Billing
If you receive services from a *non-network provider*, you may have to pay more for services you receive. *Non-network providers* may be permitted to bill you for the difference between what we 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 amount* limit.

When receiving care at a *network* facility, it is possible that some hospital-based providers (for example, assistant surgeons, hospitalists, and intensivists) may not be under contract with us as *network providers*. 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 us.

As a member, *non-network providers* should not bill you for *covered services* for any amount greater than your applicable *network cost sharing* responsibilities when:
1. 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.
2. 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.
3. 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.

Please refer to your Schedule of Benefits for an overview of your costs for out-of-network services.

ACCESS TO CARE

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

- 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 *network PCPs* at our website and using the "find a Provider" function or by calling the telephone number shown on the front page of this *policy.* You should get to know your *PCP* and establish a healthy relationship with them. Your *PCP* will:

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

Your *network PCP* will be responsible for coordinating all covered health services with other *network providers.*

Changing Your Primary Care Physician (PCP)
You may change your *network PCP* for any reason, but not more frequently than once a month, by submitting a written request, online at our website at ambetterofoklahoma.com, or by contacting our office at the number shown on your *member* 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 1-833-492-0679 (TTY: 711) 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 appointment, call 24 hours in advance. At every appointment, make sure you bring your *member* identification card and 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 1-833-492-0679 (TTY: 711). A licensed nurse is always available and ready to answer your health questions. In an *emergency*, call 911 or head straight to the nearest *emergency* room.

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

Non-Emergency Services Outside of Service Area
If you are traveling outside of the Oklahoma *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 Oklahoma by searching the relevant state in our Provider Directory at Guide.AmbetterHealth.com. Not all states have Ambetter plans. If you receive care from an Ambetter provider outside of the *service area*, you may be required to receive *prior authorization* for non-emergency services. Contact Member Services at the phone number on your *member* identification card for further information. Except for *dependents* living outside of the *service area*, *members* traveling outside of the *service area* will be responsible for ensuring that their *non-network providers* obtain *prior authorization* to be eligible for benefits for any non-emergency health services, including admissions to non-network facilities. We apply our medical coverage policies to all requests when evaluating the *medical necessity* for *non-network provider* services, which includes considering the absence of or the exhaustion of all *network* resources. Failure to request *prior authorization* will result in denial of coverage.

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

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

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

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

- New technology
- New medical procedures
- New drugs
- New devices

- New application of existing technology

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

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

Preferred Partnership
As innovative technologies and solutions are established in market under expedited research and development, we may elect to offer, at our discretion, new services or preferred partnerships designed to improve access to care and enhance *care management*. Ambetter will provide access to *third party* services at preferred or discounted rate. The preferred or discounted rates to these services may be communicated to all *members* by email, mail or phone promotions. The preferred partnerships are optional benefits to all *members*.

Hospital Based Providers
When receiving care at a *network hospital* it is possible that some *hospital*-based providers (for example, assistant surgeons, hospitalists, and intensivists) may not be under contract with us as *network providers*. If appropriate notice is provided to and acknowledged by you before rendering services, you may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by us – this is known as "balance billing". We encourage you to inquire about the providers who will be treating you before you begin your treatment, so you can understand their participation status with us. Any amount you are obligated to pay to the non-network provider in excess of the *eligible service expense* will not apply to your *deductible amount* or *maximum out-of-pocket amount*

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

MAJOR MEDICAL EXPENSE BENEFITS

Essential health benefits are defined by federal law and refer to benefits in at least the following categories: ambulatory patient services, *emergency services*, hospitalization, maternity and newborn care, mental health and *substance use disorder* services (including *behavioral health* treatment), *prescription drugs*, rehabilitative and *habilitative services* and devices, laboratory services, preventive and wellness services, chronic disease management and pediatric services (including oral and vision care). Essential health benefits provided within this certificate 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.

This *policy* provides coverage for health care services for *members* and *dependents.* Some services require *prior authorization*. *Copayment, deductibles, and coinsurance amounts* must be paid to your *network provider* or *non-network provider* at the time services are rendered. *Covered services* are subject to all *policy* provisions, including conditions, terms, limitations and exclusions. *Covered services* must be *medically necessary* and not *experimental or investigational*.

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

Acquired Brain Injury Services
Benefits for eligible 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 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 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 expenses will include ambulance services for ground and water transportation, transportation from home, scene of accident, or medical *emergency*:

1. To the nearest *hospital* that can provide services appropriate to the *covered person's illness* or *injury*, in cases of *emergency*; or
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; or
3. Transportation between *hospitals* or between a *hospital* and *skilled nursing* or *rehabilitation facility* and *member's* home when *authorized* by Ambetter of Oklahoma.
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 state 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 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 of Oklahoma.
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 air ambulance provider, beyond your cost share, for air ambulance services.

Limitations: Benefits for air ambulance services are limited to:

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

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

Exclusions:
No benefits will be paid for:

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

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

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

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

Chiropractic Services
Chiropractic services are covered when a chiropractor finds services are *medically necessary* to treat or diagnose neuromusculoskeletal disorders on an outpatient basis. *Covered expenses* are subject to all other terms and conditions of the *policy*, including *copayments, deductible amount* and *coinsurance amount* provisions.

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

- The *investigational* item or service itself;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Clinical trials must meet the following requirements:

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

"Clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, funded or approved by:

- One of the National Institutes of Health (NIH);
- The Centers for Disease Control and Prevention;
- The Agency for Health Care Research and Quality;
- The Centers for Medicare & Medicaid Services;
- A cooperative group or center of any of the entities listed above or the Department of Defense or the Department of Veteran Affairs;
- An NIH Cooperative Group or Center;
- The FDA in the form of an *investigational* new drug application;
- The federal Departments of Veterans' Affairs, Defense, or Energy;
- An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects;
  The study or investigation is a drug trial that is exempt from having such an *investigational* new drug application; or
- A qualified non-governmental research entity that meets the criteria for NIH Center support grant eligibility.

In a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. A *qualified individual* must be eligible to participate in the clinical trial, and either (a) have a referral from a doctor stating that the clinical trial would be appropriate based upon the individual having 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 be appropriate based on the individual having 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 Ambetter of Oklahoma upon request.

Colorectal Cancer Examinations and Laboratory Tests

Covered service expenses include colorectal cancer tests for any non-symptomatic *covered person*, in accordance with the current American Cancer Society guidelines. *Covered services* includes tests for *covered persons,* who are at least 45 years of age; or less than 45 years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

Contraception and Family Planning

All FDA-approved contraception methods (identified on www.fda.gov) are approved for *members* without *cost sharing* as required under the Affordable Care Act. *Members* have access to the methods available and

outlined on our Drug Formulary or Preferred Drug List without *cost share*. Some contraception methods are available through a *member's* medical benefit, including the insertion and removal of the contraceptive device under preventive care at no *cost share* to the *member* (when provided by a contracted provider).. These benefits include the following for adolescent and adult women, and are 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.

Diabetic Care

For *medically necessary* services and supplies used in the treatment of persons with gestational, type I or type II diabetes. *Covered expenses* include, but are not limited to, examinations including podiatric examinations; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine or ketone strips, blood glucose monitor supplies, glucose strips for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication; and one retinopathy examination screening per year. Any additional diabetes equipment, related supplies and health care provider services that are *medically necessary* for the treatment of diabetes as determined on an annual basis by The State Board of Health as being *medically necessary* for the treatment of diabetes will also be *covered expenses*, subject to the terms of this *policy* and provided any equipment and supplies have been approved by the federal Food and Drug Administration (FDA).

Insulin: The total amount you will be required to pay for a covered insulin medication will not exceed $30 per 30-day supply or $90 per 90-day supply. If your cost share per 30-day supply of insulin medication is less than $30 or 90-day supply of insulin medication is less than $90, you will be responsible for the lower amount. Please refer to our formulary for tier placement of insulin medications and your *Schedule of Benefits* for your *cost share* responsibility for the associated drug tier.

Dialysis Services
Medically necessary acute and chronic dialysis services are *covered services* unless other coverage is primary, such as Medicare for dialysis. There are two types of treatment provided you meet all the criteria for treatment. You may receive hemodialysis or peritoneal dialysis in your home 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*; and
4. Dialysis treatment of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

After you receive appropriate training at a dialysis facility we designate, we 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 (DME), 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.

Durable medical equipment

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

Covered services may include, but are not limited to:

1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for IV fluids and medicine.
5. Glucometer.
6. Tracheotomy tube.
7. Cardiac, neonatal and sleep apnea monitors.
8. Augmentive communication devices are covered when we approve based on the *member's* condition.

Exclusions:

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

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

Medical and surgical supplies

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

Covered services may include, but are not limited to:

1. Allergy serum extracts.
2. Chem strips, glucometer, lancets.
3. Clinitest.

4. Needles/syringes.
5. Ostomy bags and supplies except charges such as those made by a pharmacy for purposes of a fitting are not *covered services*.
6. Disposable medical supplies, which have a primary medical purpose, are covered and are subject to reasonable quantity limits as determined by us. Examples include, but are not limited to: bandages & wraps, gloves, suction catheters, surgical sponges, hypodermic needles, syringes, and applicators. The supplies are subject to the *member's deductible, copayment,* and/or *coinsurance amounts*.

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 surgical bras, as required by the Women's Health and Cancer Rights Act. Maximums for *prosthetic devices*, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are *covered services*. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract *surgery* or *injury*; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of *surgery* are not considered contact lenses, and are not considered the first lens following *surgery*. If the *injury* is to one eye or if cataracts are removed from only one eye and the *member* selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Cochlear implant.

7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (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*.

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).

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

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

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

Exclusions:
Non-covered services include but are not limited to:
1. Foot support devices, such as arch supports, unless they are an integral part of a leg brace.
2. Standard elastic stockings and other supplies not specially made and fitted (except as specified under the Medical Supplies provision above).
3. Garter belts or similar devices.

Habilitation Expense Benefits
The following are *covered expenses* for *habilitation services:*
1. Physical, occupational and speech therapies; and
2. Developmental services and *durable medical equipment* for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder.

Habilitative services include, but are not limited to, toileting, dressing, using fine motor skills, crawling, walking, categorization, expressing oneself (making wants and needs known), picture recognition, identifying letters, numbers, shapes, etc., appropriate play skills and coping mechanisms.

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

1. *Home health aide services* only if provided in conjunction with skilled registered nurse or licensed practical nursing services.
2. Skilled services of a registered nurse or licensed practical nurse rendered on an outpatient basis.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.* Please refer to your *Schedule of Benefits* for any limits associated with this benefit.
4. Intravenous. medication and pain medication.
5. Hemodialysis, and/or for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental of *medically necessary durable medical equipment* at our discretion.

Charges under (4) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

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

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

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

Hospice Care Service Expense Benefits
Hospice care benefits are allowable for a *terminally ill covered person* receiving *medically necessary* care under a *hospice* care program or in a home setting.

The list of *covered service expenses* includes:

1. Room and board in a *hospice* while the *covered person* is an *inpatient;*
2. Occupational therapy;
3. Speech-language therapy;
4. The rental of medical equipment while the *terminally ill covered person* is in a *hospice* care program to the extent that these items would have been covered under the *policy* if the *covered person* 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 *covered person* regarding the *covered person's terminal illness;*
7. *Terminal illness counseling* of the *covered person's immediate family;* and
8. *Bereavement counseling*.

Exclusions and Limitations:
Any exclusion or limitation contained in the *policy* 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*;*
3. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision; or
4. Respite care.

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

1. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
2. A private hospital room when needed for isolation.
3. Daily room and board and nursing services while confined in an *intensive care unit*.
4. *Inpatient* use of an operating, treatment, or recovery room.
5. Outpatient use of an operating, treatment, or recovery room for *surgery.*
6. Services and supplies, including drugs and medicines, which are routinely provided by the *hospital* to persons for use only while they are *inpatients.*
7. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See your *Schedule of Benefits* for limitations.

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

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

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

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

- Complex wound care:
    - Daily physician monitoring of wound
    - Wound requiring frequent complicated dressing changes, and possible repeated debridement of necrotic tissue
    - Large wound with possible delayed closure, draining, and/or tunneling or high output fistulas
    - Lower extremity wound with severe ischemia
    - Skin flaps and grafts requiring frequent monitoring
- Infectious disease:
    - Parenteral anti-infective agent(s) with adjustments in dose
    - Intensive sepsis management

- Common conditions include osteomyelitis, cellulitis, bacteremia, endocarditis, peritonitis, meningitis/encephalitis, abscess and wound infections

- Medical complexity:
  - Primary condition and at least two other actively treated co-morbid conditions that require monitoring and treatment
  - Common conditions include metabolic disorders, stroke, heart failure, renal insufficiency, necrotizing pancreatitis, emphysema (COPD), peripheral vascular disease, and malignant/end-stage disease
- Rehabilitation:
  - Care needs cannot be met in a rehabilitation or skilled nursing facility
  - Patient has a comorbidity requiring acute care
  - Patient is able to participate in a goal-oriented rehabilitation plan of care
  - Common conditions include CNS conditions with functional limitations, debilitation, amputation, cardiac disease, orthopedic surgery
  - Mechanical ventilator support:
  - Failed weaning attempts at an acute care facility
  - Patient has received mechanical ventilation for 21 consecutive days for 6 hours or more/day
  - Ventilator management required at least every 4 hours as well as appropriate diagnostic services and assessments
  - Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions
  - Patient is hemodynamically stable and not dependent on vasopressors
  - Respiratory status is stable with maximum PEEP requirement 10 cm H2O, and FiO2 60% or less with O2 saturation at least 90%
  - Common conditions include complications of acute lung injury, disorders of the central nervous and neuromuscular systems, and cardiovascular, respiratory, and pleural/chest wall disorders

Patient continues to meet the criteria above and does not meet the criteria to be transitioned to alternate level of care.

Infertility

Covered service expenses under this benefit are provided for *medically necessary* diagnostic and exploratory procedures to determine infertility. In addition, coverage is provided for *surgical procedures* to correct a medically diagnosed disease or condition of the reproductive organs including, but not limited to, treatment of the following:

- Endometriosis;
- Collapsed/clogged fallopian tubes; or
- Testicular failure.

This benefit is subject to *deductible* and *coinsurance*/*copayment*.

No benefits will be payable for charges related to artificial insemination, in vitro fertilization (IVF), embryo transplant, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT).

Lymphedema

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

Mammography Screening
Covered expenses for a *covered person* shall be paid at the following frequency schedule: Age 35 through 39, one baseline mammogram; Age 40 and older, one mammogram every year. Mammograms without regard to age are covered, upon recommendation from a *physician*, when there is a prior history of breast cancer, family history of breast cancer, positive genetic testing or other risk factors. Low-dose mammography screening for the presence of occult breast cancer is not subject to *cost sharing*.

Maternity Care
Coverage for maternity care: 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, childbirth classes, and *hospital* stays for delivery or other *medically necessary* reasons less any applicable *deductible*, or *coinsurance*. An *inpatient* stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a cesarean delivery. We do not require a *physician* or other *health care provider* to obtain *prior authorization* for delivery. An *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require notification to the health plan.

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

1. 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;
2. *Physician* home visits and office services;
3. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests;
4. *Complications of pregnancy;*
5. *Hospital* stays for other *medically necessary* reasons associated with maternity care; and
6. Home births performed by a licensed/certified midwife or health care professional.

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*. Please refer to the Dependent Member Coverage section of this document 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 Non Covered Services and Exclusions section. *Members* who are a *surrogate* at the time of enrollment or *members* who agree to a *surrogacy arrangement* during the plan year must, within 30 days of enrollment or agreement to participate in a *surrogacy arrangement*, send us written notice of the *surrogacy arrangement* to Ambetter of Oklahoma, Member Services, 14000 Quail Springs Parkway, Suite 650, Oklahoma City, OK 73134. In the event that a *member* fails to comply with this provision, we reserve our right to enforce this *policy* on the bases of fraud, misrepresentation or false information, up to and including recoupment of all benefits that we paid on behalf of the *surrogate* during the time that the *surrogate* was insured under our *policy*, plus interest, attorneys' fees, costs and all other remedies available to us.

Newborns' and Mothers' Health Protection Act Statement of Rights
If expenses for *hospital* confinement in connection with childbirth are otherwise included as *covered 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 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. In any case, issuers may not, under federal law, require that a provider obtain *prior authorization* from the issuer for prescribing a length of stay not in excess of 48 hours or 96 hours.

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 *policy* to restrict any terms, limits, or conditions that may otherwise apply to *surrogates* and children born from *surrogates*. Please refer to General Non-Covered Services and Exclusions section, as limitations may exist.

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

We also cover nutritional services for the treatment of cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, or kidney disease. Benefits for medical foods are exempt from any *deductible* requirements.

Exclusions: any other non-medical dietary formulas, oral nutritional supplements, special diets, prepared foods/meals and formula for access problems.

Medical and Surgical Expense Benefits
Medical *covered services* and supplies are limited to charges:

1. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies;
2. For the professional services of a *medical practitioner,* including *surgery*;
3. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies;*
4. For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included);
5. For chemotherapy and radiation therapy or treatment;
6. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components;
7. For the cost and administration of an anesthetic;
8. For oxygen and its administration;
9. For accidental *dental services* when a *covered person* suffers an *injury,* after the *covered person's effective date* of coverage, that results in:

a. Damage to the *member's* natural teeth; and
b. Expenses are a part of a treatment plan that was prescribed by a *physician*.
c. *Injury* to the natural teeth will not include any *injury* as a result of chewing.

10. For reconstructive breast *surgery* charges as a result of a partial or total mastectomy. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas;
11. For *medically necessary chiropractic care* treatment on an outpatient basis only. See your *Schedule of Benefits* for benefit levels or additional limits.
12. For the following types of tissue transplants:
    a. Cornea transplants;
    b. Artery or vein grafts;
    c. Heart valve grafts;
    d. Prosthetic tissue replacement, including joint replacements; and
    e. Implantable prosthetic lenses, in connection with cataracts;
13. Family Planning for certain professional provider contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.
14. Cochlear implants and bone anchored hearing aids;
15. Audiological services and hearing aids (limited to one per ear each four year period);
16. *Medically necessary services* made by a *physician* who renders services in a *network urgent care center*, including facility costs and supplies;
17. Radiology services, including X-ray, Magnetic Resonance Imaging (MRI), Computed Tomography (CAT) scan, Positron Emission Tomography (PET scan), and ultrasound imaging.
18. Allergy testing;
19. *Medically necessary telehealth services* subject to the same clinical and *utilization review* criteria, plan requirements and limitations as the same health care services when delivered to an insured in person. *Telehealth Services* provided by Ambetter Telehealth Vendors are subject to $0 *copay*. *Telehealth Services* not provided by Ambetter Telehealth Vendors would be subject to the same *cost sharing* as the same health care services when delivered to 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.
20. For *medically necessary* genetic blood tests.
21. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV);
22. For *medically necessary* biofeedback services.
23. For *medically necessary* allergy treatment.
24. Therapeutic abortion performed to save the life of the *member*, or as required by *applicable law* .
25. Services related to diagnosis, treatment and appropriate management of osteoporosis when such services are provided by a person licensed to practice medicine and surgery in the state, if the member has a condition or medical history for which bone mass measurement is medically indicated.
26. For respiratory and pulmonary therapy.
27. For medically necessary infusion therapy.
28. Testing of pregnant women and other members for lead poisoning
29. For pulse oximetry screening on a newborn.
30. 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.
31. Newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.

32. *Medically necessary* routine footcare; *prior authorization* may be required.

Medical Vision Services
Covered services include:

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

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

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

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

Mental health services will be provided on an *inpatient* and outpatient basis and include mental health conditions. These conditions affect the *member's* ability to cope with the requirements of daily living. *Deductible amounts*, *copayment* or *coinsurance* amounts and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

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

When making coverage determinations, our *behavioral health* and *substance use disorder* Utilization Management staff utilize established level of care guidelines and *medical necessity* criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. Our *behavioral health* and *substance use* staff utilize Change Healthcare 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 or *substance use disorder* services are as follows:

Inpatient

1. *Inpatient* Psychiatric Hospitalization;
2. *Inpatient* Detoxification Treatment;
3. *Inpatient Rehabilitation*;
4. Crisis Stabilization;
5. *Residential Treatment facility* for mental health and *substance use disorders*; and
6. Electroconvulsive Therapy (ECT).

Outpatient

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

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

We oversee the delivery and oversight of covered *behavioral health* and *substance use disorder* services for us. If you need mental health or *substance use disorder* treatment, you may choose any provider participating in our *behavioral health* and *substance use provider 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 ambetterofoklahoma.com or by calling Member Services at 1-833-492-0679 (TTY: 711).

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

In addition, integrated *care management* is available for all of your health care needs, *including behavioral health* and *substance use disorders*. Please call 1-833-492-0679 (TTY: 711) to be referred to a care manager for an assessment.

Nutritional Counseling

When *medically necessary*, nutritional counseling is covered for various diagnoses – both medical and behavioral health. The goal of nutritional counseling is to help patients make and maintain dietary changes for optimal management of their specific condition and overall improvement in health.

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).

Coverage is also provided for:

1. For medically necessary oral surgery, including the following:

a. Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
b. Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw bone and is medically necessary to attain functional capacity of the affected part.
c. Oral/surgical correction of accidental injuries.
d. Treatment for Temporomandibular Joint Disorder (TMJ), including removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services.
e. Treatment of non-dental lesions, such as removal of tumors and biopsies.
f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
g. Surgical procedures that are medically necessary to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.
h. Reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance.

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

Outpatient Medical Supplies Expense Benefits

Covered expenses for outpatient medical supplies are limited to charges:

1. For artificial eyes and polishing of such, for larynx, breast prosthesis, or basic artificial limbs but not the replacement thereof, unless required by a physical change in the *covered person* and the item cannot be modified. If more than one *prosthetic device* can meet a *covered person's* functional needs, only the charge for the most cost effective *prosthetic device* will be considered a *covered expense.* Coverage provided for eligible charges shall be no less than 80 percent of Medicare allowable as defined by the Centers for Medicare & Medicaid Services, Healthcare Common Procedure Coding System;
2. For rental of *medically necessary durable medical equipment*;
3. For the rental of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint *surgery*;
4. For a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic *injury* or corneal disease, infectious or non-infectious, and (2) For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract *surgery*. See your *Schedule of Benefits* for benefit levels or additional limits; and
5. For the cost of a monofocal lens, if the multifocal lens is implanted after a cataract extraction.

Pediatric Routine Vision Benefits – Children under the age of 19

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

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

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 ambetterofoklahoma.com or call Member Services.

Services not covered:
1. Deluxe frame/frame upgrade;
2. Visual therapy (see medical coverage);
3. Two pair of glasses as a substitute for bifocals; and
4. LASIK *surgery*.

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 subsection are limited to charges from a licensed *pharmacy* for:
1. A *prescription drug*.
2. Prescribed, self-administered anticancer medication. **Note:** Coverage is provided in accordance with Oklahoma state law and prescribed orally administered anticancer medications is covered no less favorably than intravenously administered or injected cancer medications.
3. Contraceptive devices prescribed by a *physician*.
4. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician.*
5. Off-label drugs that are:

a. Recognized for treatment of the indication in at least one (1) *standard reference compendium*; or
b. The drug is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

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

Covered expenses shall include coverage for prescribed drugs or devices approved by the United States Food and Drug Administration for use as a contraceptive.

The appropriate drug choice for a *covered person* is a determination that is best made by the *covered person* and the *covered person's physician.*

Drug Synchronization
Covered expenses includes the *synchronization* of *prescription drug* refills on at least one occasion per insured per year, provided all of the following conditions are met:

1. The *prescription drugs* have been approved by a formulary exceptions process;
2. The *prescription drugs* are maintenance medications and have available refill quantities at the time of *synchronization*;
3. The medications are not Schedule II, III or IV controlled substances;
4. The insured meets all utilization management criteria to the *prescription drugs* at the time of *synchronization*;
5. The *prescription drugs* are of a formulation that can be safely split into short-fill periods to achieve *synchronization*;
6. The *prescription drugs* do not have special handling or sourcing needs as determined by the plan, contract, or agreement that require a single, designated pharmacy to fill or refill the prescription; and
7. The *covered person* agrees to the *synchronization.*

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.

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*.*

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

Exclusions and Limitations:
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 weight loss prescription drugs unless otherwise listed on the formulary;
3. For immunization agents otherwise not required under the Affordable Care Act;
4. For medication that is to be taken by the *covered person,* in whole or in part, at the place where it is dispensed;
5. For medication received while the *covered person* is a patient at an institution that has a facility for dispensing pharmaceuticals;
6. For a refill dispensed more than 12 months from the date of a *physician's* order;
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs;
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are listed on the formulary. This exclusion does not apply to prescribed FDA-approved contraceptive methods;
9. For drugs labeled "Caution - limited by federal law to *investigational* use" or for *investigational* or *experimental* drugs;
10. For more than a 30-day supply when dispensed in any one prescription or refill, or for some maintenance drugs up to a 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply *network.* Specialty drugs and other select drug categories are limited to 30-day supply when dispensed by retail or mail order;
11. For *prescription drugs* for any *covered person* who enrolls in Medicare Part D as of the date of the *covered person's* enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date;
12. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program;
13. 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;
14. 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;
15. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations;
16. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventative treatment is related to *member's* vacation for out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases;
17. Medications used for cosmetic purposes;
18. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary**;**
19. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status.
20. For infertility drugs unless otherwise listed on the formulary;
21. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office;
22. For any drug related to *surrogate pregnancy*;
23. For any injectable medication or biological product that is not expected to be self-administered by the *member* at the *member's* place of *residence* unless listed on the formulary;

24. Medication refills where a *member* has more than 15 days' supply of medication on hand; and
25. Compound drugs, unless there is at least one ingredient that is an FDA approved drug.

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

If you decide to have your prescription filled at a *network* pharmacy, you can use the Provider Directory to find a pharmacy near you. You can access the Provider Directory at ambetterofoklahoma.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 ambetterofoklahoma.com. You can also request to have a copy mailed directly to you.

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

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

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

Self-injectable Drugs
Self-injectable drugs are delivered into a muscle or under the skin with a syringe and needle. Although medical supervision or instruction may be needed in the beginning, the patient or caregiver can administer *self-injectable drugs* safely and effectively. *Self-injectable drugs* are covered under the prescription drug benefits; prescription drug cost share applies.

Formulary or Prescription Drug List
The formulary or *prescription drug* list is a guide to available generic, brand name drugs and some over-the-counter medications when ordered by a *physician* that are approved by the Food and Drug Administration (FDA) and covered through your *prescription drug* benefit. Generic drugs have the same

active ingredients as their brand name counterparts and should be considered the first line of treatment. The FDA requires generics to be safe and work the same as brand name drugs. If there is no generic available, there may be more than one brand name drug to treat a condition. Preferred brand name drugs are listed on Tier 2 of the Drug List to help identify brand name drugs that are clinically appropriate, safe and cost effective treatment option, 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.

For the most current Ambetter Formulary or Prescription Drug List or for more information about our pharmacy program visit ambetterofoklahoma.com (under "for Member", "Drug Coverage") or call Member Services at 1-833-492-0679 (TTY: 711).

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

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.

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

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

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

than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception.

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

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

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
4. With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA.

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

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

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

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

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

Notification
As required by section 2715(d)(4) of the Public Health Service Act, we will provide 60 days advance notice to you before any material modification will become effective, including any changes to preventive benefits covered under this contract. You may access our website or the Member Services Department at 1-833-510-4727 to get the answers to many of your frequently asked questions regarding preventive services.

Our website has resources and features that make it easy to get quality care. Our website can be accessed at ambetterofoklahoma.com.

Prostate Specific Antigen Testing
Covered expenses include an annual digital rectal examination and prostate specific antigen tests performed to determine the level of prostate specific antigen in the blood for a *covered person* who is at least 50 years of age; and at least once annually for a *covered person* who is less than 50 years of age and who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

Radiology, Imaging and Other Diagnostic Testing
Medically necessary radiology services, imaging and tests performed for diagnostic reasons are a *covered service* (e.g., X-ray, Magnetic Resonance Imaging (MRI), Computed Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT), mammogram, and ultrasound). *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).

In accordance with state law, any diagnostic examination for breast cancer shall not apply member cost share. A diagnostic examination may include, but is not limited to, a diagnostic mammogram, breast magnetic resonance imaging, or a breast ultrasound. Diagnostic examination for breast cancer means a *medically necessary* and clinically appropriate examination, as defined by current guidelines and as determined by a clinician who is evaluating the individual for breast cancer, to evaluate the abnormality in the breast that is:

- Seen or suspected from a screening examination for breast cancer,
- Detected by another means of examination, or
- Suspected based on the medical history or family medical history of the individual.

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

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

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

Care ceases to be *rehabilitation* upon our determination of any of the following:

1. The *member* has reached *maximum therapeutic benefit*.
2. Further treatment cannot restore bodily function beyond the level the *member* already possesses.
3. There is no measurable progress toward documented goals.

4. Care is primarily *custodial care*.

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

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

If requested, the second opinion consultation is to be provided by a provider of the *member's* choice. The *member* may select a *network provider* listed in the Provider Directory. If a *member* chooses a *network provider*, the *member* will only be responsible for the applicable *cost sharing* for the consultation. Any lab tests or diagnostic and therapeutic services are subject to additional *cost sharing*.

Skilled Nursing Facility Expense Benefits
Covered expenses include expenses incurred for services or confinement in a *skilled nursing facility*, subject to the following limitations:

1. Services or confinement in a *skilled nursing facility* must begin within 14 days of a *hospital* stay of at least three consecutive days and be for treatment of, the same *illness* or *injury* that resulted in the *hospital* stay;
2. *Covered expenses* for *provider facility* services are limited to charges made by a *hospital* or *skilled nursing 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 United States Food and Drug Administration (FDA).

Skilled nursing facility charges are limited to 30 days per *covered person* per year. See your *Schedule of Benefits* for benefit levels or additional limits.

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

Social Determinants of Health Supplemental Benefits
Social determinants of health supplemental benefits and services may be offered to *members* to remove barriers to accessing health services and improve overall health outcomes. These are benefits and services that we may make available in connection with this *policy*. The benefits and services provided may include transportation to health services, assistance with childcare, access to healthy meals, and other relevant services based on need. The benefits are available as long as coverage remains active, unless changed by us. Upon termination of coverage, the benefits are no longer available. All *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 enrollees. The benefits and services available at any given time are made part of this *policy* by this reference and are subject to change by us through an update to information available on our website or by contacting us.

Social determinants of health benefits and services may be offered to enrollees through the "My Health Pays" wellness program and through our websites. *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 ambetterofoklahoma.com or by contacting Member Services at 1-833-492-0679 (TTY: 711).

Transplant Expense Benefits
Covered expenses for transplant service expenses:

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

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

1. If both the donor and recipient have coverage provided by the same insurer each will have their benefits paid by their own coverage program.
2. If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this *policy* will be provided for both you and the donor. In this case, payments made for the donor will be charged against enrollees benefits.
3. If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this *policy* 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 *covered person and donor are* appropriate candidates for a *medically necessary* transplant*,* live donation, *covered expenses* will be provided for:

1. Pre-transplant evaluation;
2. Pre-transplant harvesting of the organ from the donor;
3. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant);
4. Including outpatient *covered services* related to the transplant *surgery*, pre-transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection, and other immunosuppressive drug therapy, etc. Also included is the cost for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. Coverage is limited to a maximum cost of $75 per transplant;
5. Pre-transplant stabilization, meaning an *inpatient* stay to *medically stabilize* a *covered person* to prepare for a later transplant, whether or not the transplant occurs;
6. The transplant itself, including the acquisition cost for the organ or bone marrow when *authorized* through the *Center of Excellence* and services are performed at a participating facility;
7. Post-transplant follow-up visits and treatments;
8. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors; and
9. All costs incurred and medical expenses by the donor; shall be paid under the transplant recipient *policy*, this excludes travel, lodging, food, and mileage. Please refer to the "Member Transplant Travel Reimbursement Policy" for outlined details on reimbursement limitations at ambetterofoklahoma.com.

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

Ancillary "*Center Of Excellence*" Service Benefits:
A *covered person* may obtain services in connection with a *medically necessary* transplant from any *physician*. However, if a transplant is performed in a *Center of Excellence:*

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

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these Transplant Service Expense Benefits:

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *medically necessary* transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the *Center of Excellence*.
4. To keep a donor alive for the transplant operation, except when *authorized* through the *Center of Excellence*.
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ*.*
6. Related to transplants unauthorized through the *Center of Excellence* and is not included under this provision as a transplant.
7. The acquisition cost for the organ or bone marrow, when provided at an unauthorized facility or not obtained through the *Center of Excellence*.
8. For any transplant services and/or travel related expenses for the enrollee and donor, when performed outside of the United States.
9. The following ancillary items listed below, will not be subject to *member* reimbursement under this *policy*:
    a. Alcohol/tobacco
    b. Car Rental (unless pre-approved by Case Management)
    c. Vehicle Maintenance for motorized, 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 *policy* as *eligible service expenses*
s. Any fuel costs/charging station fees for electric cars

Organ Transplant Medication Notification

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

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

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

Members are encouraged to contact their *PCP* for an appointment before seeking care from another provider, but *network urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *PCP* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-833-492-0679 (TTY: 711). The 24/7 Nurse Advice Line is available 24 hours a day, seven days a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

Wellness Program Benefits
Benefits may be available to enrollees for participating in certain programs that we may make available in connection with this *policy*. Such programs may include wellness programs, disease or *care management*

programs. 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 ambetterofoklahoma.com or by contacting Customer Service by telephone at 1-833-492-0679 (TTY: 711). The benefits are available as long as coverage remains active, unless changed by us as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All enrollees are eligible for program benefits upon obtaining coverage. The programs are optional, and the benefits are made available at no additional cost to the enrollees. The programs and benefits available at any given time are made part of this *policy* 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 1-833-492-0679 (TTY: 711).

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to you or your covered *dependent* in the absence of insurance covering the charge.
2. Expenses, fees, taxes or surcharges imposed on you or your covered *dependent* by a provider, including a *hospital*, but that are actually the responsibility of the provider to pay.
3. Any services performed by a *member of the member's immediate family.*
4. Any services not identified and included as *covered expenses* under the *policy*. 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.

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*.
2. For any portion of the charges that are in excess of the *eligible service expense.*
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery,* bariatric *surgery* and weight loss programs*.*
4. For the reversal of sterilization and the reversal of vasectomies.
5. For abortion, except as described in the Medical and Surgical Expense Benefits provision under the Major Medical Expense Benefits section.
6. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered expenses* of the Major Medical Expense Benefits provision.
7. For expenses for television, telephone, or expenses for other persons;
8. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
9. For telephone consultations between providers, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
10. For stand-by availability of a *medical practitioner* when no treatment is rendered.
11. For *dental service* expenses*,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits.
12. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect.
13. For mental health examinations and services involving:
    a. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities*;*
    b. Pre-marital counseling;
    c. Court-ordered care or testing, or required as a condition of parole or probation. Benefits will be allowed for services that are *medically necessary* and would otherwise be covered under this *policy*;
    d. Testing of aptitude, ability, intelligence or interest; and
    e. Evaluation for the purpose of maintaining employment. Benefits will be allowed for services that would otherwise be covered under this *policy*.

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 *policy*.
17. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*.
18. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the *policy*.
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 hearing aids, except as expressly provided in this *policy*.
21. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of 90 consecutive days.
22. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *covered person* 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 *covered person'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 *covered person'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.
23. *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*.
    k. Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except where the child is the adoptive child of insureds possessing an active *policy* with us and/ or the child possesses an active *policy* with us at the time of birth.
24. For fetal reduction *surgery*.
25. Except as specifically identified as a *covered expense* under the *policy*, expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, dry needling, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
26. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or semi-professional sports;

intercollegiate sports not including intramural sports; racing or speed testing any motorized vehicle or conveyance, if the *covered person* is paid to participate or to instruct; racing or speed testing any non-motorized vehicle or conveyance, if the *covered person* is paid to participate or to instruct; rodeo sports; horseback riding, if the *covered person* is paid to participate or to instruct; rock or mountain climbing, if the *covered person* is paid to participate or to instruct; or skiing, if the *covered person* is paid to participate or to instruct.

27. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *covered person* 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.
28. For *prescription drugs* for any *covered person* who enrolls in Medicare Part D as of the date of the *covered person's* enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
29. For the following miscellaneous items: artificial insemination (except where required by federal or state law); biofeedback; care or complications resulting from non-covered 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; *rehabilitation* services for the enhancement of job, athletic or recreational performance; routine or elective care outside the *service area*; treatment of spider veins; transportation expenses; unless specifically described in this *policy*.
30. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment. Benefits will be allowed for services that would otherwise be covered under this *policy*.
31. For any medicinal and recreational use of cannabis or marijuana.
32. For any non-medically necessary court ordered care for a medical/surgical or mental health/*substance use disorder* diagnosis, unless required by state law.
33. Expenses for services related to immunizations for travel and occupational purposes.
34. Expenses for services related to *respite care*.
35. Expenses for services related to massage therapist.
36. Expenses, services, and treatments from a naprapatic specialists for conditions caused by contracted, injured, spasmed, bruised, and or otherwise affected myofascial or connective tissue.
37. Expenses, services, and treatments from a naturapathic specialist for treatment of prevention, self-healing and use of natural therapies.

TERMINATION

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *policy*;
2. The date we receive a request from you to terminate this *policy,* 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. The date we decline to renew this *policy,* as stated in the Discontinuance provision;
4. The date of your death, if this *policy* is an individual plan;
5. The date a *member's* eligibility for coverage under this *policy* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *policy*; or
6. The date a *member's* eligibility for coverage under this *policy* ceases as determined by the Health Insurance Marketplace.

Refund upon Cancellation
We will refund any premium paid and not earned due to *policy* termination. You may cancel the *policy* at any time by 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, but in any event shall return the unearned portion of the premium within 30 days. The earned premium shall be computed on a daily pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the *effective date* of the cancellation.

Reinstatement
We will reinstate a *policy* when it is erroneously terminated or cancelled. The reinstatement will result in restoration of the enrollment with no break in coverage.

If you enrolled through the Marketplace and your benefits were terminated because you did not pay your premium in full by the end of your grace period, you will not be able to reinstate your benefits.

If you did not enroll through the Marketplace and if any renewal premium is not paid within the time granted for payment, a subsequent acceptance of premium by us*,* which is not part of a new application, shall reinstate benefits under this *policy*. However, if we require an application for reinstatement and issue a conditional receipt for the premium tendered, benefits under the *policy* will be reinstated upon approval of the application by us*.* If we do not provide you with an approval or disapproval within 45 days of issuing the conditional receipt, then the *policy* will be reinstated. The reinstated *policy* shall cover only loss resulting from accidental *injury* sustained after the date of reinstatement and loss due to *illness* that may begin ten (10) days after such date. In all other respects, you shall have the same rights as you had under the *policy* immediately before the due date of the defaulted premium, subject to any provisions endorsed or attached in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Discontinuance
90-Day Notice: If we discontinue offering and decide not to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 90 days prior to the date that we discontinue coverage. You will be offered an option to purchase any other coverage in the individual market we offer in your state at the time of discontinuance of this *policy*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180-Day Notice: If we discontinue offering 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.

RIGHT OF REIMBURSEMENT

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

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

If this plan provides benefits under this *policy* to a *covered person* for expenses incurred due to *third party injuries*, then the plan retains the right to repayment of the full cost of all benefits provided by this plan on behalf of the *covered person* that are associated with the *third party injuries*. The plan's rights of recovery apply to any recoveries made by or on behalf of the *covered person* from any source, including, but not limited to:

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

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

By accepting benefits under this plan, the *covered person* also specifically acknowledges Ambetter of Oklahoma's right of reimbursement. This right of reimbursement attaches when this plan has provided health care benefits for expenses incurred due to *third party injuries* and the *covered person* or the *covered person*'s *authorized representative* has recovered any amounts from any source. By providing any benefit under this plan, Ambetter of Oklahoma is granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by this plan. Ambetter of Oklahoma's right of reimbursement is cumulative with and not exclusive of Ambetter of Oklahoma's subrogation right and Ambetter of Oklahoma may choose to exercise either or both rights of recovery.

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

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

all benefits associated with *third party injuries* provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement);

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

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

COORDINATION OF BENEFITS

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

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

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

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

1. If a plan is advised by a *covered person* that all plans covering the person are high-*deductible* health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-*deductible* health plan's *deductible* is not an allowable expense, except for any health care expense incurred that may not be subject to the *deductible* as described in Section 223 (c)(2)(C) of the Internal Revenue Code of 1986.
2. An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.
3. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a *covered person* is not an allowable expense.

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

a. If a person is confined in a private *hospital* room, the difference between the cost of a semi-private room in the *hospital* and the private room is not an allowable expense, unless one of the plans provides coverage for *hospital* room expenses.
b. If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.
c. If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated frees is not an allowable expense.
d. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefits or services for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

The term "Plan" includes:

1. Group and non-group insurance contracts and subscriber contracts;
2. Uninsured arrangements of group or group-type coverage;
3. Group and non-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. The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contract; and
7. Medicare or other governmental benefits, as permitted by law.

The term "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. Limited benefit health coverage;
5. School accident-type coverages that cover students for accident only, including athletic *injures*, wither on a 24 hour basis or on a "to and from school" basis;
6. Benefits provided in long-term care insurance policies of 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 benefits without regard to expense incurred or the receipt of services;
7. Medicare supplement polices;
8. A state plan under Medicaid; or
9. A governmental plan, which by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

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

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

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

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 1-7 that applies will determine which plan will be primary:

1. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. A plan may consider benefits paid or provided by another plan in determining its benefits only when it is secondary to that *other plan*.
2. If the *other plan* does not contain a coordination of benefits provision that is consistent with this provision, that plan is always primary. There are two exceptions:
    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a *covered person* may continue to be excess to such basic benefits.

3. Each plan determines its order of benefits using the first of the following rules that apply:
    a. 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.
    b. *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:
        (i) If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the *calendar year* (excluding year of birth) shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary.
        (ii) If a child is covered by both parents' plans, the parents are separated or divorced, whether or not they have ever been married:
            A. If a court order or 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 the plan years commencing after the plan is given notice of the court decree;
            B. If a court order or decree states that both parents are responsible for or orders joint custody without considering for the *dependent* child's health care expenses or health care coverage, the provisions of subparagraph (i) above shall determine the order of benefits.
            C. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the step-parent's plan will pay second, and the plan of the parent without custody will pay third;
            D. If there is no court order or 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:
                1) The plan covering the custodial parent;
                2) The plan covering the *spouse* of the custodial parent;
                3) The plan covering the non-custodial parent; and then
                4) The plan covering the *spouse* of the non-custodial parent.
        (iii) For a *dependent* child covered under more than one plan of individuals who are the parents of the child, the provisions of subparagraph i or ii above shall determine the order of benefits as if those individuals were the parents of the child.
4. Active Employee or Retired or Laid-off Employee. If the person receiving services is covered under one plan as an active employee or *member* (i.e., not laid-off or retired), or as the *spouse* or child of such an active employee, and is also covered under another plan as a laid-off or retired employee, the plan that covers such person as an active employee or *spouse* or child of an active employee will be primary. If the *other plan* does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored. This rule does not apply if the rule 3(a) can determine the order of benefits.

5. 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 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 3(a) can determine the order of benefits.
6. 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.
7. 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.

Effects of Coordination
When this plan is secondary, we may reduce 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, we will calculate the benefits we would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under this plan that is unpaid by the primary plan. We may then reduce our 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, we shall credit to our plan *deductible* any amounts we would have credited to the *deductible* in the absence of other health care coverage. Also, the amount we pay will not be more than the amount we would pay if we were primary. When this plan is secondary as a result of one of our *members* being a Medicare beneficiary, see above definition for allowable expense, as we will reduce our benefits up to Medicare's allowable.

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

Right of Recovery
If the amount of the payments made by this plan is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the *covered person*. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services. If the *covered services* provided by us exceed the total amount of benefits that should have been paid under this section, we have the right to recover from one or more of the following claimant:

1. Any person to or from whom such payments were made; or
2. *Member* was non eligible at the time of service; or
3. Insurance companies.

We have the right to recover from any claimant 12 months after payment is made, and/or request a refund from a health care provider 18 months after payment is made.

CLAIMS

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

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

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

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

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

To request reimbursement for a *covered service,* you need a copy of the detailed claim from your provider. You will also need to submit a copy of the member reimbursement claim form posted at AmbetterofOklahoma.com under "Member Resources". Send all the documentation to us at the following address:

Ambetter of Oklahoma
Attn.: Claims Department
PO Box 5010
Farmington, MO 63640-5010

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

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

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

Time for Payment of Claims
Benefits will be paid within 30 days for clean claims filed electronically or on paper. "Clean claims" means a claim submitted by you or a provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If we have not received the information we need to process a claim, we will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information. In those cases, we cannot complete the processing of the claim until the additional information requested has been received. We will make our request for additional information within 20 days of our initial receipt of the claim and will complete our processing of the claim within 30 days after our receipt of all requested information.

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

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

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

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

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

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

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

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

Assignment
We will reimburse a *hospital* or *health care provider* if:
1. Your health insurance benefits are assigned by you in writing; and
2. We approve the assignment.

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

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

We will pay the benefits of this *policy* to the state if:
1. A *covered person* is eligible for coverage under the state's Medicaid program; and
2. We receive proper *proof of loss* and notice that payment has been made for *covered expenses* under that program.

Our payment to the state will be limited to the amount payable under this *policy* for the *covered 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 *covered person*, 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 *policy*;
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 *covered person* while a claim is pending or while a dispute over the claim is pending. These examinations are made at our expense and as often as we may reasonably require.

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

GRIEVANCE AND COMPLAINT PROCEDURES

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

An eligible grievant is:
1. A claimant;
2. A person *authorized* to act on behalf of the claimant. **Note:** Written *authorization* is not required; however, if received, we will accept any written expression of *authorization* without requiring specific form, language, or format;
3. In the event the claimant is unable to give consent: a *spouse*, family member, or the treating provider; or
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given *authorization* to represent the claimant.

Important: *Adverse benefit determinations* that are not *grievances* will follow standard Patient Protection and Affordable Care Act (PPACA) internal *appeals* processes.

Grievances
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.

Claimants should submit all documentation to us at:

Ambetter of Oklahoma
PO Box 10341
Van Nuys, CA 91410
1-833-886-7956

Grievances will be promptly investigated and presented to the internal *grievance* panel. 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. We are required to provide continued coverage pending the outcome of an *appeal*. A request for an *appeal* must be submitted within 180 days following receipt of an *adverse benefit determination*.

Resolution Timeframes
1. *Grievances* regarding quality of care, quality of service, or *reformation* will be resolved within 30 calendar days of receipt. The time period may be extended for an additional 30 calendar days, making the maximum time for the entire *grievance* process 60 calendar days if we provide the *claimant* and the *claimant's authorized representative*, if applicable, written notification of the following within the first 30 calendar days:
   a. That we have not resolved the *grievance*;
   b. When our resolution of the *grievance* may be expected; and
   c. The reason why the additional time is needed.
2. All other *grievances* will be resolved and we will notify the *claimant* in writing with the *appeal* decision within the following timeframes:
   a. *Post-service claim*: within 30 calendar days after receipt of the *claimant*'s request for internal *appeal*; or

b. *Pre-service claim*: within 30 calendar days after receipt of the *claimant*'s request for internal *appeal*.

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. 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 tendays. 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; or
2. The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer. The plan will give the claimant 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.

Acknowledgement

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

When acknowledging a *grievance* filed by an *authorized representative*, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.

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

Right to Appear

The claimant who filed the *grievance*, or the claimant's *authorized representative*, has the right to appear in person before the *grievance* panel to present written or oral information. The grievant may submit written questions to the person or persons responsible for making the determination that resulted in the *grievance*.

1. Written notification must be sent to the claimant indicating the time and place of the *grievance* panel meeting at least seven calendar days before the meeting; and
2. Reasonable accommodations must be provided to allow the claimant, or the claimant's *authorized representative*, to participate in the *grievance* panel.

Grievance Panel

The *grievance* panel will not include the person who made the initial determination and is not the subordinate of the original reviewer. The panel may, however, consult with the initial decision-maker. If the

panel consists of at least three persons, the panel may then include no more than one subordinate of the person who made the initial determination.

The *grievance* panel will include:

1. At least one individual *authorized* to take corrective action on the *grievance*; and
2. At least one insured other than the grievant, if an insured is available to serve on the *grievance* panel. The insured member of the panel shall not be an employee of the plan, to the extent possible.

When the *adverse benefit determination* is based in whole or in part on a medical judgment, the *grievance* panel will consult with a licensed *health care provider* with expertise in the field relating to the *grievance* and who was not consulted in connection with the original *adverse benefit determination*.

Expedited Grievance

An *expedited grievance* 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.

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

Due to the 72-hour resolution timeframe, the standard requirements for notification, *grievance* panel/right to appear, and acknowledgement do not apply to *expedited grievances*.

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

Written Grievance Response

Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial, determination, or initiation of disenrollment.
The panel's 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*;
3. The signature of one voting member of the panel; and
4. A written description of position titles of panel members involved in making the decision.
5. If upheld or partially upheld, it is also necessary to include:
    a. A clear explanation of the decision;
    b. Reference to the specific plan provision on which the determination is based;
    c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to 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 claim amount;
j. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
k. The health plan's denial code with corresponding meaning;
l. A description of any standard used, if any, in denying the claim;
m. A description of the external review procedures, if applicable;
n. The right to bring a civil action under state or federal law;
o. A copy of the form that authorizes the health plan to disclose protected health information, if applicable;
p. That assistance is available by contacting the specific state's consumer assistance department, if applicable; and
q. A culturally linguistic statement based upon the claimant's county or state of *residence* that provides for oral translation of the *adverse benefit determination*, if applicable.

Complaints
Basic elements of a *complaint* include:
1. The complainant 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 *complaints* - "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;
4. Written expressions of dissatisfaction regarding quality of care/quality of service are processed as *grievances*;
5. Oral expressions of dissatisfaction regarding quality of care/quality of service are processed as *complaints* as indicated in standard oral *complaint* instructions; and
6. Any of the issues listed as part of the definition of *grievance* received from the *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.

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*.

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.

You may request an external review from:

Oklahoma Insurance Department
400 N. E. 50th Street
Oklahoma City, Oklahoma 73105
Telephone: (1-800) 522-0071 or (1-405) 521-2828

Applicability/Eligibility

The g*rievance* procedures apply to:

1. Any *hospital* or medical *policy* or certificate; excluding accident only or disability income only insurance; or
2. Conversion plans.

After exhausting the internal review process, the claimant has four months to make a written request to the Insurance Commissioner for external review after the date of receipt of our internal response. You may request an external review by submitting an External Review Request Form that is available on the Oklahoma Insurance Department's website. Within one (1) business day after the date of receipt of a request for external review, the Insurance Commissioner will send a copy of the request to us.

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 grievance* or we either provide a waiver of this requirement or fail to follow the *appeal* process;
2. A health plan must allow a claimant to make a request for an expedited external review with the plan at the time the 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 grievance* would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an internal *expedited grievance*; 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 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 grievance* is requested and an Independent Review Organization (IRO) will determine if the internal *expedited grievance* needs to be completed before proceeding with the expedited external review.

External review is available for *grievances* that involve:

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

External Review Process

1. We have five business days (immediately for expedited external review requests) following receipt of the request to conduct a preliminary review of the request to determine whether:
   a. The individual was a *covered person* at the time the item or service was requested;

b. The service is a *covered service* under the claimant's health plan but for the plan's *adverse benefit determination* with regard to *medical necessity experimental/investigational*, medical judgment, or *rescission*;
c. The claimant has exhausted the internal process; and
d. The claimant has provided all of the information required to process an external review.

2. Within one business day (immediately for expedited external review requests) after completion of the preliminary review, we will notify the Insurance Commissioner and the claimant in writing as to whether the request is: (1) complete and eligible for external review; (2) complete but not eligible for external review and the reasons for its ineligibility; or (3) not complete and the additional information needed to make the request complete;
3. Within one (1) business day of receiving notice that a request is eligible for external review (immediately for expedited external review requests), the Insurance Commissioner will assign an IRO;
4. Within five business days after the date of assignment of the IRO (or upon receipt of notice of the assignment of an IRO in the case of an expedited external review request), 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. Upon receipt of any information submitted by the claimant, the IRO must forward the information to us within one business day;
7. Upon receipt of the information, we may reconsider our determination. If we reverse our *adverse benefit determination*, we must provide written notice of the decision to the claimant and the IRO within one business day after making such decision. The external review would be considered terminated;
8. Within 45 days (72 hours for expedited external reviews) after the date of receipt of the request for an external review by the health plan, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to the claimant and to us. If the notice for an expedited review is not in writing, the IRO must provide written confirmation within 48 hours after the date of providing the notice; and
9. 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*.

Appeals and Grievances filing and key communication timelines

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

GENERAL PROVISIONS

Entire Contract
This *policy, the Schedule of Benefits, and* the enrollment application, including any amendments or riders attached, is the entire contract between you and us. No agent may:

1. Change this *policy*;
2. Waive any of the provisions of this *policy*;
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 *policy* that will not be considered a waiver of any rights under the *policy*. A past failure to strictly enforce the *policy* will not be a waiver of any rights in the future, even in the same situation or set of facts.

Repayment for Fraud, Misrepresentation or False Information
After two years from the date of issue of this *policy*, no misstatements, except fraudulent misstatements, made by the applicant in the enrollment application for such policy shall be used to void the policy or to deny a claim based upon such misstatement. During the first two years a *member* is covered under the *policy*, if a *member* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *policy* or in filing a claim for *policy* benefits, we have the right to demand that *member* pay back to us all benefits that we provided or paid during the time the *member* was covered under the *policy*.

Conformity with Applicable Laws
Any part of this *policy* in conflict with *applicable laws* on this *policy'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 ambetterofoklahoma.com/privacy-practices or call Member Services at 1-833-492-0679 (TTY: 711).

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 ambetterofoklahoma.com/language-assistance.

Statement of Non-Discrimination

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

Ambetter of Oklahoma:

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

If you need these services, contact Ambetter of Oklahoma at 1-833-492-0679 (TTY 711).

If you believe that Ambetter of Oklahoma has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ambetter of Oklahoma, Appeals and Grievances, PO Box 10341 Van Nuys CA, 91410, 1-833-492-0679 (TTY 711), Fax 1-833-886-7956. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter of Oklahoma is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Declaración de no discriminación

Ambetter of Oklahoma cumple con las leyes federales de derechos civiles aplicables y no discrimina en base a raza, color, origen nacional, edad, discapacidad o sexo. Ambetter of Oklahoma no excluye a las personas ni las trata de manera distinta debido a su raza, color, origen nacional, edad, discapacidad o sexo.

Ambetter of Oklahoma:

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

Si necesita estos servicios, comuníquese con Ambetter of Oklahoma 1-833-492-0679 (TTY 711).

Si cree que Ambetter of Oklahoma no le ha brindado estos servicios o le ha discriminado de otra manera por motivos de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja ante: Ambetter of Oklahoma, Appeals and Grievances, PO Box 10341 Van Nuys CA, 91410, 1-833-492-0679 (TTY 711), Fax 1-833-886-7956. Usted puede presentar una queja por correo, fax, o por correo electrónico. Si necesita ayuda para presentar una queja, Ambetter of Oklahoma está disponible para usted. Además puede presentar un reclamo de derechos civiles al U.S. Department of Health and Human Services (Departamento de Salud y Servicios Humanos de EE.UU.), Office for Civil Rights (Oficina de Derechos Civiles) electrónicamente a través del Portal para reclamos de la Oficina de Derechos Civiles, disponible en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, o por correo o teléfono en: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

ambetter of Oklahoma

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter of Oklahoma, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-492-0679 (TTY 711).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter of Oklahoma , 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 1-833-492-0679 (TTY 711).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter of Oklahoma 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 1-833-492-0679 (TTY 711)。
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter of Oklahoma 에 관해서 질문이 있다면 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-833-492-0679 (TTY 711)번으로 전화하십시오.
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter of Oklahoma 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 1-833-492-0679 (TTY 711) an.
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حولAmbetter of Oklahoma، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-833-492-0679 (TTY 711).
Burmese:	သင် သို့မဟုတ် သင်ကူညီပေးနေသော တစ်ယောက်ယောက်တွင် Ambetter of Oklahoma နှင့် ပက်သက်ပြီး မေးမြန်းလိုသည်များ ရှိလျှင် အကူအညီ နှင့် အချက်အလက်များကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရယူပိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန်တစ်ယောက် နှင့် ပြောဆိုရန် 1-833-492-0679 (TTY 711) ကို ဖုန်းဆက်ပါ။
Hmong:	Yog koj, los yog ib tug neeg uas koj pab ntawd, muaj lus nug txog Ambetter of Oklahoma koj muaj cai tau txais tej ntub ntawv no sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-833-492-0679 (TTY 711)
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter of Oklahoma, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-833-492-0679 (TTY 711).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter of Oklahoma, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-833-492-0679 (TTY 711).
Laotion:	ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ Ambetter of Oklahoma, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ ໃຫ້ໂທຫາ 1-833-492-0679 (TTY 711).
Thai:	หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีคำถามเกี่ยวกับAmbetter of Oklahoma ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข 1-833-492-0679 (TTY 711).
Urdu:	اگر Ambetter of Oklahoma کے بارے میں آپ کے، یا جن کی آپ مدد کر رہے ہیں، ان کے سوالات ہوں تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی مترجم سے بات کرنے کے لیے 1-833-492-0679 (TTY 711) پر کال کریں۔
Cherokee:	ᏂᎯ ᎠᏯ ᎯᏍᏕᎸᏍᎩ ᏍᏊ ᎠᏛᏛᎲᏍᎩ ᎬᏩᏚᏫᏛ Ambetter of Oklahoma, ᏙᏩ ᎠᏊ ᎡᏍᏕᏗᎢ ᎠᏯ ᎡᏣᏃᏍᏐᏗ ᏨᏍᏌ ᏣᏬᏂᎯᏍᏗ ᏂᎦ ᎬᏩᏛᏫ. ᏍᏓᏩᏃᏢᏗ ᎩᏣ ᎠᏁᏗᏍᎩ ᏗᏍᏫ 1-833-492-0679 (TTY 711)
Persian:	اگر شما، يا كسي كه به او كمک مي كنيد سؤالي در مورد Ambetter of Oklahoma داريد، از اين حق برخورداريد كه كمک و اطلاعات را بصورت رايگان به زبان خود دريافت كنيد. براي صحبت كردن با مترجم با شماره 1-833-492-0679 (TTY 711) تماس بگيريد.

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