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2023 Evidence of Coverage

Ambetter.WellCareKy.com

72001KY002-2023

Ambetter from WellCare of Kentucky

Home Office: WellCare of Kentucky 13551 Triton Park Boulevard Louisville, KY 40223

Major Medical Expense Insurance Policy

In this *policy,* the terms "you" or "your" will refer to the *member* or any *dependent members* named in the enrollment application. The terms "we," "our," or "us" will refer to Ambetter from WellCare of Kentucky.

AGREEMENT AND CONSIDERATION

This document along with the corresponding *Schedule of Benefits,* your enrollment application and any amendments and/or riders attached*,* is your *policy* with Ambetter from WellCare of Kentucky and 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 health care benefits to you, the *member*, for *covered services* as outlined in this *policy*. Benefits are subject to *policy* definitions, provisions, limitations, and exclusions.

READ YOUR POLICY CAREFULLY

This cover sheet provides only a brief outline of some of the important features of your *policy*. This cover sheet is not the insurance *policy* and only the actual *policy* provisions will control. The *policy* itself sets forth, in detail, the rights and obligation of both you and your insurance company. IT IS THEREFORE IMPORTANT THAT YOU READ YOUR *POLICY*.

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

At least 60 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. You may be required to obtain a referral from a *primary care physician (PCP)* in order to receive care from a *specialist physician*. Benefits may be reduced or not covered if the requirements are not met. Please refer to your *Schedule of Benefits* and the Prior Authorization section.

TEN DAY RIGHT TO RETURN POLICY

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

Ambetter from WellCare of Kentucky

Corey Ewing
CEO and Plan President

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Introduction

Welcome to Ambetter from WellCare of Kentucky! This *policy* has been prepared by us to help explain your coverage. Please refer to this *policy* whenever you require medical services.

It describes:

- How to access medical care.
- What health services are covered by us.
- What portion of the health care costs you will be required to pay.

This *policy*, the *Schedule of Benefits*, the enrollment application as submitted to the Kentucky Health Benefit Exchange (Exchange), and any amendments and riders attached shall constitute the entire *policy* under which *covered services* and supplies are provided or paid for by us.

This *policy* should be read in its entirety. Since many of the provisions are interrelated, you should read the entire *policy* to get a full understanding of your coverage. Many words used in the *policy* have special meanings. These words are *italicized* and are defined for you in the Definitions section. This *policy* also contains exclusions, so please be sure to read this *policy* carefully.

How to Contact Us
Ambetter from WellCare of Kentucky
13551 Triton Park Blvd., Suite 1800
Louisville, KY 40023

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST
Member Services: 1-833-705-2175
TTY line: Relay 711
Fax: 1-833-959-3828
Emergency: **911**
24/7 Nurse Advice Line: 1-833-705-2175 or for the hard of hearing (TTY: Relay 711)

Interpreter Services
Ambetter from WellCare of Kentucky 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 1-833-705-2175 or for the hard of hearing (TTY: Relay 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 or 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 on 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 https://guide.ambetterhealth.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 *PCP* about what might be wrong (to the level known), treatment and any known likely results. Your *PCP* can tell you about treatments that may or may not be covered by the *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. Make recommendations regarding *member's* rights, responsibilities, and policies.
9. Voice *complaints* or *grievances* about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage or care provided.
10. See your medical *records*.
11. Be kept informed of covered and non-covered services, program changes, how to access services, *PCP* assignment, providers, advance directive information, referrals and *authorizations*, benefit denials, *member* rights and responsibilities, and our other rules and guidelines. We will notify you at least 60 days before the *effective date* of the modifications. Such notices shall include:
    a. Any changes in clinical review criteria; or

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

    Members also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this *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 *PCP*. You should establish a relationship with your *physician*. You may change your *PCP* 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 *PCP* to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.
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 *PCP*.
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 premiums, *deductible amount*, *copayment amount* or *coinsurance amount* on time.
15. Notify us or the entity you enrolled with 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, adding/removing a dependent, *spouse*/domestic partner becomes eligible under a different *insurer,* change of address 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 Ambetter.WellCareKy.com. We have *network physicians*, *hospitals* and other *medical practitioners* who have agreed to provide you with your health care services. You may find any of our *network providers* by completing the "Find a Provider" function on our website and selecting the Ambetter Network. There you will have the ability to narrow your search by provider specialty, zip code, gender, language spoken and whether or not they are currently accepting new patients. Your search will produce a list of providers based on your search criteria and will give you other information such as name, address, phone number, office hours, specialty and board certifications.

At any time, you can request a copy of the Provider Directory at no charge by calling Member Services at 1-833-705-2175 (Relay 711). In order to obtain benefits, you must designate a *network primary care physician* (*PCP*) for each *member.* We can also 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 1-833-705-2175 (Relay 711). We will help you make the appointment.

If you provide documentation that you received incorrect information from us about a *provider's network* status prior to a visit, you will only be responsible for the *network cost-sharing* amount and the *network deductible* or *maximum out-of-pocket amount* shall be applied.

Member Identification Card
We will mail you a *member* identification card after we receive your completed enrollment material 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 this *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 1-833-705-2175 (Relay 711). We will send you another card. A temporary identification card can be downloaded from Ambetter.WellCareKy.com.

Website
Our website helps you get the answers to many of your frequently asked questions and has resources and features that make it easy to get quality care. Our website can be accessed at Ambetter.WellCareKy.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 Practices.
6. Current events and news.
7. Our Formulary or Preferred Drug List.
8. *Deductible* and *copayment* accumulators.
9. Selecting a *PCP*.

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 Kentucky Health Benefit Exchange (Exchange) at www.Kynect.ky.gov.

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

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

For example, if you have a concern about the care you received from your *network physician* 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 health care and services you are receiving.

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

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

Please review the Provider Directory provision above and the Access to Care and Major Medical Expense Benefits 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 means *rehabilitation* for patients who will benefit from an intensive, multidisciplinary *rehabilitation* program. Patients normally received a combination of therapies such as physical, occupational and speech therapy as needed and are medically managed by specially trained *physicians*. *Rehabilitation services* must be performed for three or more hours per day, five to seven days per week, while the *member* is confined as an *inpatient* in a *hospital*, *rehabilitation facility* or *extended care facility*.

Advance premium tax credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Kentucky Health Benefit Exchange (Exchange). *Advance premium tax credits* can be used right away to lower your monthly premium costs. If you qualify, you may choose how much *advance premium tax credit* to apply to your premium each month, up to a maximum amount. If the amount of *advance premium tax credits* you receive for the year is less than the total 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 premium tax credits* for the year are more than the total amount of your premium tax credit, you must repay the excess *advance premium tax credit* with your tax return.

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

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

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

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

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 non-network care that is otherwise covered under your *policy* and that is provided by a *non-network provider* at a *network* facility or other type of *network* health care facility unless you gave informed consent before receiving the services. You also will not be responsible for *balance billing* by a *non-network provider* or non-network facility for *emergency services* or air ambulance services. See ***Balance billing*** and ***Non-network provider*** definitions for additional information. If you are balance billed in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.

Ambetter Telehealth means the preferred vendor who we have contracted with to provide *telehealth services* to *members*. Our preferred vendor contracts with providers to render *telehealth services* to *members*. These services can be accessed via https://ambetter.wellcareky.com/health-plans/our-benefits/ambetter-telehealth.html.

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

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

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

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

Balance billing means a *non-network provider* billing you for the difference between the provider's charge for a service and the *eligible expense*. *Network providers* may not balance bill you for *covered services.*

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

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

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

Calendar year means the period beginning on the initial *effective date* of this *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 care manager, assists a *member* through a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and health care benefits available to a *member*. *Care management* is instituted when mutually agreed to by us, the *member* and the *member's physician*.

Center of Excellence means a *hospital* that:

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

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

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

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

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

Copay, copayment or ***copayment amount*** means a 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 *illness, injury* or congenital anomaly.

Cost share or ***cost sharing*** means the *deductible amount, copayment amount* and *coinsurance amount* 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 means the reduction in 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 Exchange. Members of a federally recognized American Indian tribe and/or an Alaska Native may qualify for additional *cost sharing reductions*.

Covered service(s) means services, supplies or treatment as described in this *policy* which are performed, prescribed, directed or authorized by a *physician.* To be a *covered service,* the service, supply or treatment must be:

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

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

Custodial care includes (but is not limited to) the following:

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

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

Deductible or ***deductible amount*** means the amount that you must pay in a *calendar year* for *covered services* 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 amount* until the family *deductible amount* is satisfied for the *calendar year*.

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

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

Drug discount, copayment card or coupon means cards or coupons typically provided by a drug manufacturer to discount the *copayment amount* or your other out-of-pocket expenses (e.g., *deductible amount* or *maximum out-of-pocket amount*).

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

1. A natural child;
2. A legally adopted child;
3. A child placed with you for adoption;
4. A foster child placed in your custody;
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 that you enrolled with (either the Exchange or us) if your child ceases to be an *eligible child*. You must reimburse us for any benefits that we provide or pay for a child at a time when the child did not qualify as an *eligible child*.

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

1. For *network providers*: When a *covered service* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.
2. For *non-network providers*, unless otherwise required by Federal or Kentucky state law, the *eligible expense* is as follows:
    a. When a *covered emergency service* or *covered* air ambulance service is received from a *non-network provider*, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full. If the provider has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by applicable law, the *eligible expense* is the *recognized amount* as determined by us and as required by 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 balanced 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 expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full. If the provider has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by applicable law, the *eligible expense* is the *recognized amount* as determined by us and as required by applicable law. Unless you receive and sign the necessary written notice and consent document under federal law before the services are provided, you should not be *balance billed* for the difference between the amount we pay and the provider's charges, but you will be subject to *cost sharing* obligations. If you are *balance billed* in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.
    c. For all other *covered services* received from a *non-network provider* for which any needed *authorization* is received from us, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full (you will not be billed for the difference between the negotiated fee and the provider's charge). If there is no negotiated fee agreed to by the provider with us, the *eligible expense* is the greatest of the following: (i) the amount that would be paid under Medicare; (ii) the amount for *covered service* calculated using the same method we generally use to determine payments for *non-*

network providers; or (iii) the contracted amount paid to *network providers* for the *covered service*. (If there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts). In addition to applicable *cost sharing*, you may be *balance billed* for these services.

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

Emergency services (medical, *behavioral health* and *substance use disorder*) 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 affect 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 Exchange (Kynect.ky.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*.

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

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

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 based on *physician* specialty society recommendations or professional standards of care may be considered. We reserve the right to consult medical professionals in determining whether a health care service, supply or drug is *medically necessary* and is a *covered service* under the *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*.
4. Claims practices.

Habilitation or ***habilitation services*** means health care services that helps a patient keep, learn or improve skills and functioning for daily living. These services may be performed in an *inpatien*t 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 *member.*

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

1. Provided by a *home health care agency*; and
2. Prescribed and supervised by a *physician*, physician assistant (PA) or advanced practice registered nurse.

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 *illness* or *injury* requiring the *home health care.*

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

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

Hospital means an institution that:

1. Operates as a *hospital* pursuant to law.
2. Operates primarily for the reception, care, and treatment of sick or injured persons as *inpatients.*
3. Provides 24-hour nursing service by registered nurses on duty or call.
4. Has staff of one or more *physicians* available at all times.

5. Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical or mental conditions either on its premises or in facilities available to it on a prearranged basis; and
6. Is not primarily a long-term care facility; an *extended care facility*, nursing, rest, *custodial care* or convalescent home; a halfway house, transitional facility or *residential treatment facility*; a place for the aged, drug addicts, alcoholics or runaways; a facility for wilderness or outdoor programs; or a similar establishment.

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

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

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

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

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

Insurer means any insurance company; health maintenance organization; self-insurer, including a governmental plan, church plan or multiple employer welfare arrangement, not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association or nonprofit *hospital*, medical-surgical, dental or health service corporation authorized to transact health insurance business in Kentucky.

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

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

Managed drug limitations mean 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* for *covered services*, as shown in the *Schedule of Benefits*.

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

Medical practitioner includes but is not limited to a *physician*, nurse anesthetist, physician's assistant, physical therapist, speech therapist, occupational therapist 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, social worker, family counselor, marriage counselor, child counselor, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Medically necessary means our decision as to whether any medical service, supply, items or treatment a provider would render to a patient for the purpose of preventing, diagnosing or treating an *illness, injury*, disease or its symptoms in a manner that is:

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

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

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

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

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

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

Necessary medical supplies mean medical supplies that are:

1. Necessary to the care or treatment of an *illness* or *injury*;
2. Not reusable or *durable medical equipment*; and

3. Not able to be used by others.

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

Network means a group of providers or facilities (including, but not limited to *hospitals*, *inpatient* mental health care facilities, medical clinics, *behavioral health* clinics, acupuncturists, chiropractors, massage therapists, nurse practitioners, addiction medicine practitioners, etc.) who have contracts with us or our contractor or sub-contractor and have agreed to provide health care services to our *members* for an agreed upon fee. *Members* will receive most if not all of their health care services by accessing the *network*.

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

Network provider means any licensed person or entity that has entered into a contract with us 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 identified in the most current list for the *network* shown on your *member* identification card. Services received from a *non-network provider* are not covered, except for:

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

Orthotic device means a *medically necessary* custom fabricated brace or support that is designed as a component of a *prosthetic device*.

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 or medical pay, homeowner insurance medical pay, premises medical pay, nonprofit health service plans, health maintenance organization, *subscriber* contracts, self-insured group plans, prepayment plans, and Medicare when the *member* is enrolled in Medicare. *Other plan* will not include Medicaid.

Other practitioner means 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 mean both facility, ancillary, facility use, and professional charges when given as an outpatient at a *hospital*, alternative care facility, retail health clinic or other provider as determined by the *policy*. 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, such as an ambulatory surgery center. 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 an *illness* or bodily *injury* and is required to be covered by state law. A provider includes an optometrist providing services that may otherwise be rendered by a *physician* or osteopath. A *physician* does **NOT** include someone who is related to a *member* by blood, marriage or adoption or who is normally a member of the *member's* household.

Policy means this *policy* issued and delivered to you. It includes the attached pages, the *Schedule of Benefits*, the enrollment application and any amendments and/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 approval by us in advance of the claimant obtaining the medical care.

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

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

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

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

Primary care physician or ***PCP*** means a *physician* who is a family practitioner, general practitioner, internist, nurse practitioner, physician assistant, obstetrician/gynecologist or pediatrician.

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 claim, and *network* re-pricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.

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

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

Qualified health plan or ***QHP*** means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Health Insurance Marketplace through which such plan is offered in accordance with the process described in subpart K of part 155.

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

Recognized amount means the *network* cost sharing amount you are required to pay for non-network emergency care, for certain ancillary services provided by *non-network providers* at *network* facilities, and for non-network care provided at *network* facilities without the patient's informed consent. The *recognized amount* is calculated from the qualifying payment amount as outlined in federal regulation.

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.

Record means any written, printed or electronically recorded material maintained by a provider in the course of providing health services to a patient concerning the patient and the services provided. "*Record*" also includes the substance of any communication made by a patient to a provider in confidence during or in connection with the provision of health services to a patient or information otherwise acquired by the provider about a patient in confidence and in connection with the provision of health services to a patient.

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,* cardiac rehabilitation and pulmonary rehabilitation. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive rehabilitation therapy or treatment.

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

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

Rehabilitation facility does not include a facility primarily for rest, the aged, long-term care, assisted living, *custodial care,* nursing care or for care of an individual with an intellectual disability.

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

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

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

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

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

Self-injectable drugs mean *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 Kentucky to sell and market our health plans. This is where the majority of our *network providers* are located where you will receive all of your health care services and supplies. You can receive precise *service area* boundaries from our website or Member Services.

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

Specialist physician means a *physician* who is not a *PCP.*

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

Spouse means your lawful wife or husband.

Stabilized means to provide treatment that assures no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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

Substance use disorder means a disorder that affects a person's brain and behavior, leading to an inability to control his/her use of substances (e.g., alcohol, medications and legal or illegal drugs). Symptoms can range from moderate to severe, with addiction being the most severe form of a substance use disorder.

Substance use disorder benefits are defined as benefits for items or services for substance use disorder conditions listed in ICD 10 Chapter 5 (F), except for subchapter 1 (F01-09) and subchapter 8 (F70-79).

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

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

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

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

Telehealth services means a mode of delivering health care services through the use of telecommunication technologies, including but not limited to synchronous and asynchronous technology, remote patient monitoring technology, and audio-only encounters, by a health care provider to a patient or to another health care provider at a different location. *Telehealth services* shall not include:

1. The delivery of health care services through electronic mail, text, chat or facsimile unless a state agency authorized or required to promulgate administrative regulations relating to telehealth determines that health care services can be delivered via these modalities in ways that enhance recipient health and well-being and meet all clinical and technology guidelines for recipient safety and appropriate delivery of services; or
2. Basic communication between a health care provider and a patient, including but not limited to appointment scheduling, appointment reminders, voicemails or any other similar communication intended to facilitate the actual provision of health care services either in-person or via telehealth; and
3. Unless waived by the applicable federal authority, telehealth services shall be delivered over a secure communications connection that complies with the federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. secs, 1320d to 1320d-9.

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

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

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

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

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

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

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

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

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

Utilization management means a system for reviewing the appropriate and efficient allocation of health care services under a health benefit plan according to specified guidelines, in order to recommend or determine whether or to what extent, a health care service given or proposed to be given to a *member* should or will be reimbursed, covered, paid for or otherwise provided under the *policy*. The system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures and retrospective review.

Dependent Member Coverage

Dependent Member Eligibility
Your *dependent members* become eligible for insurance on the latter of:

1. The date you became covered under this *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, unless we have received notice from the entity that you have enrolled (either the Kentucky Health Benefit Exchange (Exchange) or us). Each type of *covered service* incurred by the newborn child will be subject to the *cost sharing* amount listed in the *Schedule of Benefits*. However, a covered newborn child will not be subject to the *deductible amount* for the first 31 days of coverage.

In order for the newborn child to be covered beyond the 31st day after its birth, we must receive notification of the birth. In addition, additional premium will be required to continue coverage beyond the 31st day after the date of birth. The required premium will be calculated from the 31st day after the child's date of birth. 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 Exchange 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 by the Exchange of the child's birth.

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

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

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

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

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

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

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

Ongoing Eligibility

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

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *policy*;
2. The *subscriber* residing outside the *service area* or moving permanently outside the *service area* of this *policy*;
3. 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 Kentucky Health Benefit Exchange (Exchange), the date of termination that the Exchange provides us upon your request of cancellation to the Exchange;
4. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *policy* or the date that we have not received timely premium payments in accordance with the terms of this *policy*;
5. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact (e.g., the date that a *member* accepts any direct or indirect contributions or reimbursement by or on behalf of an employer, for any portion of the premium for coverage under this *policy*); or
6. The date of a *member's* death.

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 Exchange at www.kynect.ky.gov. If you enrolled through Ambetter, you can contact Member Services at 1-833-705-2175 (Relay 711).

For Dependent Members
A *dependent member* will cease to be a *member* at the end of the premium period in which he or she ceases to be your *dependent member* due to divorce or if a child ceases to be an *eligible child.* For *eligible children*, the coverage will terminate the 31st day of December the year the *eligible child* turns 26 years of age.
A *member* will not cease to be a dependent *eligible child* solely because of age if the *eligible child* is:

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

Open Enrollment
There will be an open enrollment period for coverage on the Exchange. 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 and Limited Enrollment
A *qualified individual* has 60 days to report a qualifying event to the Exchange or by using our *enhanced direct enrollment* tool, and could be granted a 60-day special enrollment period as a result of one of the following events:

1. A *qualified individual* or *dependent member* experiences a loss of *minimum essential coverage,* non-calendar year group or individual health insurance coverage, *pregnancy*-related coverage, access to health care services through coverage provided to a pregnant enrollee's unborn child or medically needed coverage;
2. A *qualified individual* gains a *dependent member* or becomes a *dependent member* 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 C.F.R 1.5000A-(b) for one or more days during the 60 days preceding the date of marriage;

3. An individual, who was not previously a citizen, national or lawfully present individual gains such status;
4. An individual who is no longer incarcerated or whose incarceration is pending the disposition of charges;
5. A *qualified individual's* enrollment or non-enrollment in a *qualified health plan* is unintentional, inadvertent or erroneous and is the result of the error, misrepresentation or inaction of an officer, employee or agent of the Exchange or Health and Human Services (HHS) or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or inaction;
6. An enrollee adequately demonstrates to the Exchange that the *qualified health plan* in which he or she is enrolled substantially violated a material provision of its *policy* in relation to the enrollee's decision to purchase the *qualified health plan* based on plan benefits, *service area* or premium;
7. An individual is determined newly eligible or newly ineligible for *advance premium tax credits* or has a change in eligibility for *cost sharing reductions*, regardless of whether such individual is already enrolled in a *qualified health plan*;
8. A *qualified individual* or enrollee gains access to new *qualified health plans* as a result of a permanent move;
9. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
10. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a *qualified health plan* or change from one *qualified health plan* to another one time per month;
11. A *qualified individual* or enrollee demonstrates to the Exchange, in accordance with guidelines issued by Health and Human Services (HHS), that the individual meets other exceptional circumstances as the Exchange may provide.
12. A *qualified individual* or *dependent member* is a victim of domestic abuse or spousal abandonment and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
13. A *qualified individual* or *dependent member* is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 days after the qualifying event;
14. At the option of the Exchange, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a *qualified health plan* through the Exchange following termination of Exchange 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
15. A *qualified individual* newly gains access to an employer sponsor individual HRA or a Qualified Small Employer Health Reimbursement Arrangement (HRA).

The Exchange may provide a coverage *effective date* for a *qualified individual* earlier than specified in the paragraphs above, provided that either:

1. The *qualified individual* has not been determined eligible for *advance premium tax credits* or *cost sharing reductions*; or
2. The *qualified individual* pays the entire premium for the first partial month of coverage as well as all *cost sharing*, thereby waiving the benefit of *advance premium tax credits* and *cost sharing reduction* payments until the first of the next month.

Premiums

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

Grace Period
When a *member* is receiving a premium subsidy:

> After the first premium is paid, a grace period of 90 days from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period if *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 credits* on behalf of the *member* from the Department of the Treasury and will return the *advance premium tax credits* on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above. 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 period.

When a *member* is not receiving a premium subsidy:

> Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 60-day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *policy* will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. We will notify HHS, as necessary, of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the grace period.

Third Party Payment of Premiums or Cost Sharing
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. Certain tax-exempt organizations;
5. Family members; or
6. An employer for an employee under an Individual Coverage Health Reimbursement Account (ICHRA) or Qualified Small Employer Health Reimbursement Account (QSEHRA).

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

Misstatement of Age
If a *member's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

Change or Misstatement of Residence
If you change your *residence*, you must notify the Kentucky Health Benefit Exchange (Exchange) 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 and Limited Enrollment** provision in the OnGoing Eligibility section for more information.

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

Prior Authorization

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

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

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

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

1. At least five days prior to an elective admission as an *inpatient* in a *hospital*, *extended care facility* or *rehabilitation facility, hospice* facility or *residential treatment facility*.
2. At least 30 days prior to the initial evaluation for organ transplant services.
3. At least 30 days prior to receiving clinical trial services.
4. Within 24 hours of an admission for *inpatient* mental health or *substance use disorder* treatment.
5. At least five days prior to the start of *home health care*.

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

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

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

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

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

Benefits will not be reduced for failure to comply with *prior authorization* requirements prior to an emergency. 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 Complaint and Appeal 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. The medical expense has already been paid by someone else.
3. Another party has already paid or is responsible for payment of the medical expense.

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

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

Pursuant to the No Surprises Act, you may not be balanced billed for non-emergency ancillary services (emergency medicine, anesthesiology, pathology, radiology and neonatology, as well as, diagnostic services (including radiology and laboratory services)) received from a *non-network provider* at a *network hospital* or *network* ambulatory facility.

Note: 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 amount is likely more than *network* costs for the same service and might not count toward your annual *maximum out-of-pocket amount* limit.

Cost Sharing Features

Cost Sharing Features
We will pay benefits for *covered services* as described in the *Schedule of Benefits* and the Major Medical Expense Benefits 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*, *copayment amounts* and *coinsurance amounts* for some *covered services*. For example, you may need to pay a *copayment amount* or *coinsurance amount* when you visit your *physician* or are admitted into the *hospital*. The *copayment amount* or *coinsurance amount* required for each type of service as well as your *deductible amount* is listed in your *Schedule of Benefits*.

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

Deductible
The *deductible amount* means the amount of *covered services* that must be paid by each/all *members* before any benefits are provided or payable. The *deductible amoun*t does not include any *copayment amount* or *coinsurance amount*. Not all *covered services* 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 a *copayment amount* to a provider each time services are performed that require a *copayment amount. Copayment amounts,* as shown in the *Schedule of Benefits,* are due at the time of service. Payment of a *copayment amount* does not exclude the possibility of a provider billing you for any non-covered services. *Copayment amounts* do not count or apply toward the *deductible amount* but do apply toward your *maximum out-of-pocket amount*.

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

Maximum Out-of-Pocket
You must pay any required *copayment amounts* 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 expenses*.

When the annual *maximum out-of-pocket amount* has been met, additional *covered services* will be provided or payable at 100 percent of the *allowed amount*.

The amount provided or payable will be subject to:

1. Any specific benefit limits stated in the *policy*;
2. A determination of *eligible expenses*.

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

The applicable *deductible amount(s), copayment amounts* and *coinsurance amounts* are shown in 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.

Estimate for Eligible Expenses
Upon request, we will provide you with a written statement that includes a good faith estimate of the dollar amount of the allowable benefit for a service or procedure if the request includes information regarding any service or procedure to be performed by a *non-network provider*, including any service or procedure code number or diagnosis related group provided by the health care provider and the health care provider's estimated charge. The written statement will be provided to you within 10 business days from the receipt of your request.

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

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

This Evidence of Coverage is administered by Ambetter from WellCare of Kentucky and underwritten by WellCare Health Plans of Kentucky, Inc. Neither entity is an HSA trustee, HSA custodian or a designated administrator for HSAs. WellCare Health Plans of Kentucky, Inc., its designee and its affiliates, including Ambetter from WellCare of Kentucky, do not provide tax, investment or legal advice to members.

MEMBERS ARE SOLELY RESPONSIBLE FOR ADHERING TO ALL FEDERAL REGULATIONS AND GUIDELINES CONCERING HSA MAXIMUM ALLOWABLE AMOUNT, CONTRIBUTIONS AND QUALIFIED WITHDRAWALS.

IN ADDITION, EACH *MEMBER* WITH AN HSA IS RESPONSIBLE FOR NOTIFYING HIS/HER HSA CUSTODIAN OR TRUSTEE IF ENROLLMENT UNDER THEIR HSA PLAN HAS BEEN CANCELED OR TERMINATED.

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 specialist physicians*
- 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*.

Adults may designate an OB/GYN as a *network PCP*. However, you may not change your selection more frequently than once each month. If you do not select a *network PCP* for each *member,* one will be assigned. You may obtain a list of *network PCPs* at our website or by contacting Member Services.

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

Contacting Your Primary Care Physician (PCP)
To make an appointment with your *PCP*, call his/her office during business hours and set up a date and time. If you need help, call Member Services at 1-833-705-2175 and we will help you make the appointment.

If you need to cancel or change your appointment, call 24 hours in advance. At every appointment, make sure you bring your *member* identification card and a photo identification.

Should you need care outside of your *PCP's* office hours, you should call your *PCP's* office for information on receiving after hours care in your area. If you have an urgent medical problem or question or cannot reach your *PCP* during normal office hours, call our 24/7 nurse advice line at 1-833-705-2175 (Relay 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.

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 Ambetter.WellCareKy.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.

Referral Required for Maximum Benefits
You do not need a referral from your *network PCP* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians,* you may be required to obtain a referral from your *network PCP* for benefits to be payable under your *policy* or benefits payable under this *policy* may be reduced. A *network PCP* can make a referral for up to 12 months or for the *policy* period, whichever is shorter for a *member* with a chronic, disabling, congenital or life-threatening condition. Please refer to your *Schedule of Benefits*.

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

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

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

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

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

Prior Coverage
If a *member* is confined as an *inpatient* in a *hospital* on the *effective date* of this *policy* and prior coverage is 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* services after the *effective date*, your coverage will apply for *covered services* related to the *inpatient* services after your *effective date*. Your coverage requires you to notify us within two days of your *effective date* or as soon as reasonably possible so we can review and *authorize medically necessary* 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 us of the individual's need for transitional care; and (3) permit the individual to elect to continue to have their benefits for the course of treatment relating to the individual's status as a *continuing care patient* during the period beginning on the date on which the above notice is provided and ending on the earlier of (i) the 90-day period beginning on such date; or the (ii) date on which such individual is no longer a *continuing care patient* with respect to their provider or facility.

Hospital Based Providers

When receiving care at a *network hospital* it is possible that some *hospital*-based providers (for example, assistant surgeons, hospitalists and intensivists) may not be under contract with us as *network providers*. If appropriate notice is provided to and acknowledged by you before rendering services, you may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by 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 expense* will not apply to your *deductible amount* or *maximum out-of-pocket amount*.

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

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 Partnerships
As innovative technologies and solutions are established in the 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*. We will provide access to *third party* services at preferred or discounted rate. The preferred or discounted rates to these services may be communicated to all *members* by email, mail or phone promotions. The preferred partnerships are optional benefits to all *members*.

Major Medical Expense Benefits

This *policy* provides coverage for health care services for *members* and *dependent members*. Some services require *prior authorization*. *Deductible amounts*, *copayment amounts* and *coinsurance amounts* may be required to 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*.

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

Benefit Limitation
Limitations may apply to some *covered services* that fall under more than one *covered service* category. Please review limits carefully. We 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. Services 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 *policy* includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:

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

Ambulance Service Benefits

Covered services will include ambulance services for ground transportation and water transportation from home, scene of accident or medical emergency:

1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury* in cases of emergency;
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects or complications of premature birth that require that level of care;

3. Transportation between *hospitals* or between a *hospital* and a skilled nursing or *rehabilitation facility* and *member's* home when *authorized* by us;
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 Kentucky law, if you receive services from non-network ambulance providers, you may be responsible for costs above the *allowed amount*.

Benefits for ambulance services are limited to services requested by police or medical authorities at the site of an emergency.

Exclusions:
No benefits will be paid for:

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

Air Ambulance Service Benefits

Covered services will include ambulance services for transportation by fixed wing and rotary wing air ambulance from home, scene of accident or medical emergency:

1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*, in cases of emergency.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects or complications of premature birth that require that level of care.
3. Transportation between *hospitals* or between a *hospital* and a skilled nursing, *rehabilitation facility* and *member's* home when *authorized* by us.
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:** You should not be *balance billed* for services from a non-network ambulance provider, beyond your *cost share*, for air ambulance services.

Limitations: Benefits for air ambulance services are limited to:

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

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

Exclusions:
No benefits will be paid for:

1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-emergency air medical transportation.
3. Air medical transportation:
   a. Outside of the 50 United States and the District of Columbia;

b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States.

4. 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;
- *habilitation services* for individuals with a diagnosis of *autism spectrum disorder*;
- 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 amount* and/or *coinsurance amount* will apply to each provider.

Contraception

All FDA-approved contraception methods (identified on www.fda.gov) are approved for *members* without *cost sharing* as required under the Affordable Care Act. *Members* have access to the methods available and outlined on our Drug Formulary or Preferred Drug List without *cost share*. Some contraception methods are available through a *member's* medical benefit, including the insertion and removal of the contraceptive device at no *cost share* to the *member*. This benefit contains both pharmaceutical and medical methods, including:

1. Intrauterine devices (IUD), including insertion and removal;
2. Barrier methods including: male and female condoms (Rx required from provider, limited to 30 per month), diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide and spermicide alone;
3. Oral contraceptives including the pill (combined pill and extended/continuous use), and the mini pill (Progestin only), patch;
4. Other hormonal contraceptives, including inserted and implanted contraceptive devices, hormone contraceptive injections and the vaginal contraceptive ring;
5. Emergency contraception (the morning after pill);
6. Prescription based sterilization procedures for women; and
7. FDA-approved tubal ligation.

Diabetic Care

Benefits are available for *medically necessary* services and supplies used in the treatment of persons with gestational, type I or type II diabetes. *Covered services* 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 (provided by a certified, registered or licensed health care professional with expertise in diabetes), eye examinations and prescription medication.

Benefits are available for *medically necessary* items of diabetic supplies and blood glucose monitors (including non-invasive monitors and monitors for the blind) for which a *medical practitioner* has written an order.

Members that have insulin dependent diabetes, insulin using diabetes, gestational diabetes or non-insulin diabetes may need to be educated on their condition and trained to manage their condition. Coverage is available for self-management training and education, dietician visits and for the equipment and necessary supplies for the training, if prescribed by the *member's physician.*

The total amount you will be required to pay for a covered insulin drug will not exceed any state and/or federal mandated limits. See your *Schedule of Benefits* for benefit levels or additional limits.

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 services 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, Medical and Surgical Supplies, Orthotic Devices and Prosthetics

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

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

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

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

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

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- 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 cost must not be more than the purchase price. We will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are *covered services*. Payment for related supplies is a *covered service* only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the *member*; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered services and supplies 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 intravenous (I.V.) fluids and medicine.
5. Glucometer.
6. Tracheotomy tube.
7. Cardiac, neonatal, and sleep apnea monitors.
8. Augmentative communication devices are covered when we approve based on the *member's* condition.

Exclusions:
Non-covered items may include:

1. Air conditioners.
2. Ice bags/cold pack pump.
3. Raised toilet seats.
4. Rental of equipment if the *member* is in a facility that is expected to provide such equipment.
5. Translift chairs.
6. Treadmill exerciser.
7. Tub chair used in shower.

8. Vehicle installations or modifications which may include: adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.

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

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 and supplies 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 – 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 and wraps, gloves, suction catheters, surgical sponges, hypodermic needles, syringes and applicators. The supplies are subject to the *member's* medical *deductible amount*, *copayment amount* and/or *coinsurance amount*.

Exclusions:
Non-covered services and supplies include:

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. Medijectors.
7. Items usually stocked in the home for general use like band-aids, thermometers and petroleum jelly.

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

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

1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.
10. *Medically necessary* corrective footwear, *prior authorization* may be required.

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

Exclusions:
Non-covered services and supplies include:

1. Orthopedic shoes (except therapeutic shoes for diabetics).
2. Foot support devices, such as arch supports, unless they are an integral part of a leg brace.
3. Standard elastic stockings, garter belts, and other supplies not specifically made and fitted (except as specified under the **Medical and Surgical Supplies** provision above).
4. Garter belts or similar devices.

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 if:

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 and supplies 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. For *members* diagnosed with profound hearing impairment, cochlear implants, bone anchored hearing aids and related fittings.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (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).

Rehabilitation and Extended Care Facility Expense Benefits

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

1. *Covered services* 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 services* 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 United States Food and Drug Administration (FDA).
4. *Covered services* for non-provider facility services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners.*
5. Outpatient physical therapy, occupational therapy, speech therapy, cognitive therapy and post-cochlear implant aural 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*.

Habilitation Expense Benefits

Covered services include expenses incurred for *habilitation services*, subject to the following limitations:

1. *Covered services* for *habilitation services*, including physical, occupational and speech therapies, developmental services and *durable medical equipment* for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder; and
2. Habilitative developmental services examples 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 services and supplies for *home health care* are covered when your *physician*, physician assistant (PA) or advanced practice registered nurse (APRN) 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 includes the following:

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

Intravenous (I.V.) medication and pain medication are *covered services* to the extent they would have been *covered service*s during an *inpatient hospital* stay. At our option, we may *authorize* the purchase of the equipment from a *network provider* in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider we *authorize* before the purchase. If the equipment is purchased, the *member* must return the equipment to us when it is no longer in use.

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

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

Hospice Care Service Expense Benefits

This provision only applies to a *terminally ill member* receiving *medically necessary* care under a *hospice* care program or in a home setting.

The list of *covered services* include:

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

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

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

1. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice* care program; or
2. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision.

Hospital Benefits

Covered services 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 *illness* or *injury*, 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, 7 days a week.

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

Long Term Acute Care (LTACH)

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 when *medically necessary* and approved by us.

Common conditions/services that may be considered *medically necessary* for LTACH level of care includes, 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 services under this benefit are provided for *medically necessary* diagnostic and exploratory procedures to determine infertility including *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 amount*, *copayment amounts* and *coinsurance amounts*.

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

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 treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.
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 *member* suffers an *injury* that results in:
    a. Damage to the *member's* natural teeth
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within 12 months of the accident to be considered as a *covered service*; and
10. *Injury* to the natural teeth will not include any *injury* as a result of chewing;
11. For pulse oximetry screening on a newborn.
12. For well child care examinations for children through age 12, including child health supervision services based on American Academy of Pediatric Guidelines. Refer to **Preventive Services** provision for a list of well child/well baby services.
13. For newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.
14. 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.
15. For *medically necessary chiropractic care* treatment on an outpatient basis only. See your *Schedule of Benefits* for benefit levels or additional limits. *Covered services* are subject to all other terms and conditions of the *policy,* including the *deductible amount* and *cost sharing* provisions.
16. For the following types of tissue transplants:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.
    e. Implantable prosthetic lenses, in connection with cataracts.
17. For 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.
18. For *medically necessary services* made by a *physician* who renders services in a *network urgent care center*, including facility costs and supplies.
19. For radiology services, including X-ray, Magnetic Resonance Imaging (MRI), Computed Tomography (CAT scan), Positron Emission Tomography (PET scan) and ultrasound imaging.
20. For allergy testing, injections and serum.
21. For *medically necessary* genetic blood tests.
22. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
23. For *medically necessary* biofeedback services.
24. For *medically necessary* allergy treatment.
25. For *medically necessary* nutritional counseling, *prior authorization* may be required.
26. For *medically necessary* routine foot care, *prior authorization* may be required.
27. For elective abortion performed to save the life or health of the female upon whom the abortion is performed.
28. For the diagnosis and treatment of endometrioses and endometritis.
29. For *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis.
30. For 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.

31. For *medically necessary telehealth services* subject to the same clinical and utilization review criteria, plan requirements and limitations as the same health care services when delivered to a *member* in person. *Telehealth services* provided by *Ambetter Telehealth* vendors are subject to $0 *copay*. *Telehealth services* not provided by *Ambetter Telehealth* vendors 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.
32. For *medically necessary* intravenous (IV) or injected anti-cancer medication. Your *cost share* will not exceed $100 for a 30-day supply.
33. For respiratory and pulmonary therapy;
34. For cancer screenings, as follows:
    a. A pelvic examination and pap smear for any non-symptomatic woman who is a *member*, in accordance with the current American Cancer Society guidelines;
    b. A prostate examination and laboratory tests for cancer for any non-symptomatic man who is a *member*, in accordance with the current American Cancer Society guidelines; and
    c. A colorectal cancer examination and laboratory tests for cancer for any non-symptomatic *member*, in accordance with the current American Cancer Society guidelines.
35. For *medically necessary* diagnostic and laboratory and x-ray tests;
36. For the provision of nonprescription enteral formulas and food products required for *members* with inherited diseases of amino acids and organic acids. Such coverage shall be provided when the prescribing health care professional has issued a written order stating that the enteral formula or food product is *medically necessary*. Coverage for inherited diseases of amino acids and organic acids shall, in addition to the enteral formula, include food products modified to be low protein;
37. 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;
38. 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.
39. Testing of pregnant women and other *members* for lead poisoning.

Covered services are subject to all other terms and conditions of the *policy*, including the *deductible amount* and *cost sharing* provisions.

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 Addiction Equity Act of 2008.

Our *behavioral health* and *substance use disorder* Utilization Management staff oversees the delivery and oversight of covered *behavioral health* and *substance use disorder* services. If you need mental health or *substance use disorder* treatment, you may choose any provider participating in our *behavioral health* and *substance use disorder* 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 Ambetter.WellCareKY.com or by calling Member Services at 1-833-705-2175 (Relay 711). *Deductible amounts*, *copayment amounts or coinsurance amounts* and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

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

When making coverage determinations, our *behavioral health* and *substance use disorder* Utilization Management staff utilizes 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 disorder* Utilization Management staff utilizes InterQual criteria for mental health determinations and American Society of Addiction Medicine (ASAM) criteria for *substance use disorder* determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

Covered *inpatient* and outpatient mental health and/or *substance use disorder* services are as follows:

Inpatient

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

Outpatient

1. Individual and group therapy for mental health disorders and *substance use disorders*;
2. Medication assisted treatment – combines behavioral therapy and medications to treat *substance use disorders*;
3. Medication management services;
4. Outpatient detoxification programs;
5. Psychological and neuropsychological testing and assessment;
6. Evaluation and assessment for mental health and *substance use disorders*;
7. *Applied behavior analysis*;
8. *Telehealth services*;
9. Partial hospitalization program (PHP);
10. Intensive outpatient program (IOP);
11. Mental health day treatment;
12. Electroconvulsive therapy (ECT);
13. *Transcranial magnetic stimulation* (*TMS*);
14. Assertive community treatment (ACT).

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 1-833-705-2175 (Relay 711) to be referred to a care manager for an assessment.

Other Dental Services

Anesthesia and *hospital* charges for dental care, for a *member* less than 21 years of age or a *member* who is physically or mentally disabled, are covered if the *member* requires dental treatment to be given in a *hospital* or outpatient ambulatory surgical facility. The indications for general anesthesia, as published in the reference manual of the *American Academy of Pediatric Dentistry*, should be used to determine whether performing dental procedures is necessary to treat the *member's* condition under general anesthesia.

Coverage is also provided for:

1. *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 *network hospital*, surgical center or office, provided to the following *members*:
    a. A *member* under the age of 21;
    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. 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. *Surgery*, excluding tooth extraction, to treat craniomandibular disorders or malocclusions.

Outpatient Medical Supplies Expense Benefits

Covered services and supplies for outpatient medical supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis or basic artificial limbs, including *medically necessary* repairs or replacement to restore or maintain a *member's* ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per year per *member*.
3. For mastectomy bras if the *member* has undergone a covered mastectomy.
4. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion and a ventilator.
5. For the rental of one Continuous Passive Motion (CPM) machine per *member* following a covered joint *surgery*.
6. For one pair of eyeglasses or contact lenses per *member* following a covered cataract *surgery*.
7. For osseointegrated auditory implants (cochlear implants) as provided for in this *policy*.
8. Routine hearing examinations and hearing aids. Hearing aids are limited to one item per affected ear once every 36 months.
9. For the diagnosis and treatment of endometrioses and endometritis.

Pediatric Routine Vision Benefits – Children under the age of 21

Coverage for vision services is provided for children, under the age of 21 through the end of the plan year in which they turn 21 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;
    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 Ambetter.WellCareKY.com or call Member Services.

Covered services not covered:

1. Deluxe frame/frame upgrade;
2. Visual therapy (see medical coverage);
3. Two pair of glasses as a substitute for bifocals;
4. LASIK *surgery*.

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 an eye care *specialist physician* 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 physician* may require a referral through your *PCP*.

Vision services under the medical portion of your *policy* do not include:

- Referrals to a *specialist physician* for evaluation and diagnosis of refractive error, including presbyopia, for *members* over the age of 21 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.

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 services in this benefit subsection are limited to charges from a licensed pharmacy for:

1. A *prescription drug.*
2. Prescribed oral anti-cancer medication.
3. Prescribed eye medication – coverage for one additional bottle of prescription eye drops is requested by the *member* or the prescribing practitioner at the time the original prescription is distributed to the *member*; and the prescribing practitioner indicates on the original prescription that the additional bottle is needed for use in a day care center or school.
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 *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.

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

Formulary or Prescription Drug List

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

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

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the formulary. For the most current Ambetter Formulary or Prescription Drug List or for more information about our pharmacy program, visit Ambetter.WellCareKy.com (under “For Member”, “Drug Coverage”) or call Member Services at 1-833-705-2175 (Relay 711).

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 order* filled at a *network* pharmacy, you can use the Provider Directory to find a pharmacy near you. You can access the Provider Directory at Ambetter.WellCareKy.com on the "Find a Provider" page. You can also call Member Services to help you find a pharmacy. At the pharmacy, you will need to provide the pharmacist with your *prescription order* and your *member* identification card.

We also offer a three-month (90-day) supply of maintenance medications by mail or from *network* retail pharmacies for specific benefit plans. These drugs treat long-term conditions or *illnesses*, such as high blood pressure, asthma and diabetes. You can find a list of covered medications on Ambetter.WellCareKy.com. You can also request to have a copy mailed directly to you.

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

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

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

Drug Discount, Copayment Card or Coupon
Cost sharing paid on your behalf for any prescription drugs obtained by you through the use of a *drug discount, copayment card, or coupon* provided by a *prescription drug* manufacturer will apply towards your plan *deductible amount* or your *maximum out-of-pocket amount* for any brand name drug where a generic version:

1. Is not available on the formulary;
2. Is available on the formulary, but you have obtained access to the brand name drug through *prior authorization*, step therapy or the prescription drug exception process, as described below; or
3. Is available on the formulary, but you need access to the brand name drug through the request of a prescription drug exception process, including any *appeal* of a denial of an exception request.

Lock-In Program
To help decrease overutilization and abuse, certain *members* identified through our Lock-In Program, may be locked into a specific pharmacy for the duration of their participation in the Lock-In Program. *Members* locked into a specific pharmacy will be able to obtain their medications(s) only at specified location. Ambetter Pharmacy, together with Medical Management will review *member* profiles and using specific

criteria, will recommend *members* for participation in the Lock-In Program. *Members* identified for participation in the Lock-In Program and associated providers will be notified of *member* participation in the program via mail. Such communication will include information on duration of participation, pharmacy to which *member* is locked-in, and any *appeals* rights.

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 the **Prescription Drug Exception Process** provision for additional details.

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.

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

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

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

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

External exception request review
If we deny a request for a standard exception or for an expedited exception, the *member*, the *member's* authorized representative or the *member's* prescribing *physician* may request that the original exception request and subsequent denial of such request be reviewed by an independent review organization. We will make our determination on the external exception request and notify the *member*, the *member's*

authorized representative or the *member's* prescribing *physician* of our coverage determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception.

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

Step Therapy Exception Process
Under Kentucky law you or your *provider* have the right to request an exception to our step therapy (*prior authorization*) criteria. We will grant an exception within 48 hours of receiving all necessary information in following circumstances:

- The required *prescription drug* is:
  a. Contraindicated or will likely cause an adverse reaction by physical or mental harm to you; or
  b. Expected to be ineffective based on your known clinical characteristics and the *prescription drug* regimen;
- Based on clinical appropriateness, the required *prescription drug* is not in your best interest because your use of the required *prescription drug* is expected to:
  a. Cause a significant barrier to your adherence to or compliance with your plan of care;
  b. Worsen your comorbid condition; or
  c. Decrease your ability to achieve or maintain reasonable functional ability in performing daily activities;
- You have tried the required *prescription drug* while under your current or a previous health plan, or another *prescription drug* in the same pharmacologic class or with the same mechanism of action, and the *prescription drug* was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event; or
- You are stable on the *prescription drug* selected by your health care *provider* for the medical condition under consideration while under a current or previous health plan.

We will respond to requests for step therapy exemption that are complete withing 48 hours. If we do not respond within 48 hours the request will be deemed granted.

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

1. For *prescription drug* treatment of erectile dysfunction or any enhancement of sexual performance, unless such treatment is listed on the formulary.
2. For weight loss *prescription drugs,* unless otherwise listed on the formulary.
3. For immunization agents, blood or blood plasma, except when used for preventive care and listed on the formulary.
4. For medication that is to be taken by the *member,* in whole or in part, at the place where it is dispensed.
5. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
6. For a refill dispensed more than 12 months from the date of a *physician's* order.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are listed on the formulary.

9. For drugs labeled "Caution - limited by federal law to investigational use" or for *experimental or investigational* drugs.
10. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program.
11. For more than a 30-day supply when dispensed in any one prescription or refill or for some maintenance drugs, up to 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply network. Specialty drugs and other select drug categories are limited to 30-day supply when dispensed by retail or mail order. **Note:** Only the 90-day supply is subject to the discounted *cost sharing*. Mail orders less than 90 days are subject to the standard *cost sharing* amount.
12. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
13. Foreign Prescription Medications, except those associated with an emergency medical condition while you are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this document if obtained in the United States.
14. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventive treatment is related to *member's* vacation during out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
15. For medications used for cosmetic purposes.
16. For infertility drugs, unless otherwise listed on the formulary.
17. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
18. For drugs or dosage amounts determined by Ambetter's Pharmacy and Therapy committee to be ineffective, unproven or unsafe for the indication for which they have been prescribed, regardless of whether such drugs or dosage amounts have been approved by any governmental regulatory body for that use.
19. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
20. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status
21. For any drug related to *surrogate pregnancy*.
22. For any injectable medication or biological product that is not expected to be self-administered by the *member* at *member's* place of *residence,* unless listed on the formulary.
23. Medication refills where a *member* has more than 15 days' supply of medication on hand.
24. Compound drugs unless there is at least one ingredient that is an FDA approved drug.
25. For any prescription or over-the-counter version of vitamin(s) unless otherwise included on the formulary.
26. For immunization agents otherwise not required by the Affordable Care Act.

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 Immunizations 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 including breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one breast pump per *pregnancy.*

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

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

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

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

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

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 *member* in the trial.

Phase I and II 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 *member* is enrolled in the clinical trial. This section shall not apply to *members* who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

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

- 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;
- 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; 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. There must be equal to, or superior, non-investigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational alternatives.

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

Cancer-Related Genetic Testing

Cover services will be provided for any genetic test (blood, saliva or tissue typing) to determine the risk for cancer that is recommended by any of the following, if the recommendation is consistent with the most recent version of genetic testing guidelines published by the National Comprehensive Cancer Network (NCCN):

1. A *physician*, physician assistant or genetic counselor; or
2. An advanced practice registered nurse.

Benefits for cancer-related genetic testing are exempt from any *cost sharing* provisions under the *policy* when the services are provided by a *network provider.*

Colorectal Cancer Examinations and Laboratory Tests

Covered services include colorectal cancer tests for any non-symptomatic *member*, in accordance with the current American Cancer Society guidelines. *Covered services* include tests for *members* starting at age 45. (**Note:** Screening should start before age 45 for high-risk individuals.)

Lymphedema Benefit

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

Mammography

Covered services for routine screenings for breast cancer shall include screenings at the following intervals: one screening mammogram to persons age 35 through 39; one mammogram every two years for persons ages 40 through 49; and one mammogram per year for a person 50 years of age and over. In addition, coverage for mammography will be provided to any *member*, regardless of age, who has been diagnosed with breast cancer, when such services are referred by a *medical practitioner* acting with the scope of the practitioner's license.

In addition, coverage for mammography will be provided to *members*, regardless of age who have been diagnosed with breast cancer.

Maternity Care

Coverage for 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 amounts*, *copayment amounts* or *coinsurance amounts*). An *inpatient* stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a cesarean delivery. Other maternity benefits include *complications of pregnancy,* parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests. Coverage will only be provided for maternity services or care of the newborn child when such services have been authorized by your *network provider*. We do not require that a *physician* or other health care provider obtain *prior authorization* for delivery. An *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require notification to us.

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 services* incurred for a shorter stay if the attending provider (e.g., your *physician*, nurse, midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

Note: This provision does not amend the *policy* to restrict any terms, limits or conditions that may otherwise apply to *covered services* for maternity care.

1. Give birth in a *hospital* or other health care facility
2. Remain under *inpatient* care in a *hospital* or other health care facility for any fixed term following the birth of a child

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

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* (*deductible amount*, *copayment amount*, *coinsurance amount* and *maximum out-of-pocket amount*), as listed in your *Schedule of Benefits*. However, a covered newborn child does not need to meet the *deductible amount* for the first 31 days of coverage. 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 written notice of the *surrogacy arrangement* to Ambetter from WellCare of Kentucky at Member Services 13551 Triton Park Blvd., Suite 1800 Louisville, KY 40023. In the event that a *member* fails to comply with this provision, we reserve our right to enforce this *policy* on the basis 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 services provided or expenses incurred for *hospital* confinement in connection with childbirth are otherwise included as *covered services*, we will not limit the number of days for these expenses to less than that stated in this provision.

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

In addition, we cover a 100 percent human diet, if the 100 percent human diet and supplemented milk fortifier products are prescribed for the prevention of necrotizing enterocolitis and associated comorbidities and are administered under the direction of a *physician*.

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

Prostate Specific Antigen Testing
Covered services 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 *member* who is at least 50 years of age; and at least once annually for a *member* 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, 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).

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

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 *illness* or *injury* 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 *physician* of the *member's* choice. The *member* may select a *network provider* listed in the Provider Directory. If a *member* chooses a *network provider*, he or she will only be responsible for the applicable *cost sharing* for the consultation. Any lab tests and/or diagnostic and therapeutic services are subject to additional *cost sharing*.

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 *members*. 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 *members* 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 Ambetter.WellCareKy.com or by contacting Member Services at 1-833-705-2175 (Relay 711).

Transplant Expense Benefits

Covered services for transplant service expenses:

Transplants are a *covered service* when a *member* is accepted as a transplant candidate and pre-authorized in accordance with this *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 *member's* benefits.
3. If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this *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 *member* and donor are an appropriate candidate for a *medically necessary* transplant, live donation, *covered services* 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.
5. Pre-transplant stabilization, meaning an *inpatient* stay to *medically stabilization* to prepare for a later transplant, whether or not the transplant occurs.
6. The transplant itself, including the acquisition cost for the organ or bone marrow when authorized through the *Center of Excellence* and services are performed at a *network* facility.
7. Post-transplant follow-up visits and treatments.
8. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.
9. All costs incurred and medical expenses by the donor; shall be paid under the transplant recipient policy, this excludes travel, lodging, food and mileage. Please refer to the "Member Transplant Travel Reimbursement Policy" for outlined details on reimbursement limitations at https://ambetter.wellcareky.com/resources/handbooks-forms.html.

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

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

1. We will pay for the following services when the *member* is required to travel more than 75 miles from their *residence* to the *Center of Excellence*:
2. We will pay a maximum of $10,000 per transplant service for the following services:
    a. Transportation for the *member*, any live donor, and the *immediate family* to accompany to and from the *Center of Excellence*, in the United States.
    b. When *member* and/or donor is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
    c. Maximum reimbursement for mileage is limited to travel to and from the *member's* home to the transplant facility, and to and from the donor's home to the transplant facility and will be reimbursed at the current IRS mileage standard for miles driven for medical purposes.
    d. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence* in the United States. We will reimburse *members* for the proof of costs directly related for transportation, lodging and any of the 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 *member* and/or donor.
    f. Please refer to the *member* resources page for *member* reimbursement transplant travel forms and information at https://ambetter.wellcareky.com/resources/handbooks-forms.html.

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 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 though the *Center of Excellence* and is not included under this provision as a transplant.
7. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (FDA) regulation, regardless of whether the trial is subject to FDA oversight.
8. The acquisition cost for the organ or bone marrow, when provided at an unauthorized facility or not obtained through the *Center of Excellence*.
9. For any transplant services and/or travel related expenses for *member* and donor, when preformed outside of the United States.
10. 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 and hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.)
    d. Parking, such as but not limited to hotel, valet or any offsite parking other than *hospital*.
    e. Storage rental units, temporary housing incurring rent/mortgage payments.
    f. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
    g. Speeding tickets
    h. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
    i. For any services related to pet care, boarding, lodging, food, and/or travel expenses; other than those related to certified/registered service animal(s).
    j. Expenses for persons other than the patient and his/her covered companion
    k. Expenses for lodging when *member* is staying with a relative
    l. Any expense not supported by a receipt
    m. Upgrades to first class travel (air, bus, and train)
    n. Personal care items (e.g., shampoo, deodorant, clothes)
    o. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA pre-check, and early check-in boarding fees, extra baggage fees.
    p. Souvenirs (e.g., t-shirts, sweatshirts, toys)
    q. Telephone calls/mobile bills, replacement parts or cellular purchases of any type.
    r. All other items not described in the *policy* as *eligible expenses*
    s. Any fuel costs/charging station fees for electric cars.

Organ Transplant Medication Notification

At least 60 days prior to making any formulary change that alters the terms of coverage for a patient receiving immunosuppressant drugs or discontinues coverage for a prescribed immunosuppressant drug that a patient is receiving, we must, to the extent possible, notify the prescribing *physician* and the patient or the parent or guardian if the patient is a child or the *spouse* of a patient who is authorized to consent to the treatment of the patient. The notification will be in writing and will disclose the formulary change, indicate that the prescribing *physician* may initiate an *appeal*, and include information regarding the procedure for the prescribing *physician* to initiate the *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 a *network 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 1-833-705-2175 (Relay 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 *members* 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 Ambetter.WellCareKy.com or by contacting Member Services by telephone at 1-833-705-2175 (Relay 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 *members* are automatically eligible for program benefits upon obtaining coverage. These programs are optional, and the benefits are made available at no additional cost to the *members*. The programs and benefits available at any given time are made part of this *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 1-833-705-2175 (Relay 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 the *member* in the absence of insurance covering the charge.
2. Expenses, fees, taxes or surcharges imposed on the *member* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.
3. Any services performed by a member of the *member's immediate family.*
4. Any services not identified and included as *covered services* under the *policy*. You will be fully responsible for payment for any services that are not *covered services.*
5. Any services where other coverage is primary to us must be first paid by the primary payor prior to consideration for coverage under this *policy*.
6. Any non-medically necessary court ordered care for a medical/surgical or mental health/*substance use disorder* diagnosis, unless required by state law.

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

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

Covered services 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 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, except as specifically covered in the Major Medical Expense Benefits section of this *policy*.
4. For the reversal of sterilization and the reversal of vasectomies.
5. For non-elective 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 service expenses* of the Medical and Surgical 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 failure to keep a scheduled appointment.
10. For stand-by availability of a *medical practitioner* when no treatment is rendered.
11. For *dental service* expenses*,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under the Major Medical Expense Benefits section.
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 in a child.
13. Mental health services are excluded for:
    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.

14. For charges related to or in preparation for, tissue or organ transplants, except as expressly provided for under the **Transplant Expense Benefits** provision.
15. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
16. While confined primarily to receive *rehabilitation, custodial care,* educational care or nursing services (unless expressly provided for in this *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 expressly provided for in this *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. As a result of an *illness* or *injury* arising out of or in the course of, employment for wage or profit, if the *member* is insured or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's* workers' compensation claim, this exclusion will still apply unless that denial is *appealed* to the proper governmental agency and the denial is upheld by that agency.
21. For fetal reduction *surgery*.
22. Except as specifically identified as a *covered service* under this *policy*, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
23. 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 *member* is paid to participate or to instruct); racing or speed testing any non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).
24. As a result of any *injury* sustained while operating, riding in or descending from any type of aircraft if the *member* is a pilot, officer or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
25. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
26. For the following miscellaneous items: artificial insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-covered services; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the **Medical Foods** provision; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-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*.
27. For diagnostic testing, laboratory procedures screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
28. For court ordered testing or care unless *medically necessary*.
29. For a *member's illness* or *injury* which 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.*

30. *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:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the *surrogate* following childbirth);
    d. Mental health services related to the *surrogacy arrangement*;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
    h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement*;
    i. Any complications of the child or *surrogate* resulting from the *pregnancy*; or
    j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*.

    Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except where the child is the adoptive child of insureds possessing an active policy with us and/or the child possesses an active policy with us at the time of birth.
31. For any medicinal and recreational use of cannabis or marijuana.
32. For expenses or services related to immunizations for travel and occupational purposes.
33. For expenses or services related to massage therapist.
34. For expenses, services and treatments from a Naprapathic *specialist physician* for conditions caused by contracted, injured spasmed, bruised and/or otherwise affected myofascial or connective tissue.
35. For expenses, services and treatments from a Naturopathic *specialist physician* for treatment of prevention, self-healing and use of natural therapies.
36. For expenses for services related to dry needling.
37. For the treatment of infertility, except as expressly provided in this *policy*.

Termination

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

1. Nonpayment of premiums when due, subject to the **Grace Period** provision in this *policy*;
2. The date we receive a request from you to terminate this *policy* or any later date stated in your request or if you are enrolled through the Kentucky Health Benefit Exchange (Exchange), the date of termination that the Exchange provides us upon your request of cancellation to the Exchange;
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 Exchange.

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 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. 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.

If you enrolled through the Exchange 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 Exchange and if any renewal premium is not paid within the time granted for payment, a subsequent acceptance by us or by any agent duly authorized by us to accept such premium, without requiring an application for reinstatement, shall reinstate benefits under this *policy*: provided, however, that if we or our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, benefits under the *policy* will be reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of such conditional receipt unless we have previously notified you in writing of disapproval of such application. The reinstated policy shall cover only *loss* resulting from such accidental *injury* as may be sustained after the date of reinstatement and *loss* due to such sickness as may begin more than 10 days after such date. In all other respects, you and we shall have the same rights thereunder as they had under the *policy* immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto 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 all policies issued on this form, 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 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 or may be or is claimed to be responsible for *illness* or *injuries* to a *member*. Such *illness* or *injuries* are referred to as "*third party* injuries." "Responsible party" includes any parties actually, possibly or potentially responsible for payment of expenses associated with the care or treatment of *third party* injuries.

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

- Payments made by a *third party* or any insurance company on behalf of the *third party*;
- Any payments or awards under an uninsured or underinsured motorist coverage 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 *member* for *third party* injuries.

By accepting benefits under this *policy*, the *member* specifically acknowledges our right of recovery. When this *policy* provides health care benefits for expenses incurred due to *third party* injuries, we shall be included in the *member's* rights of recovery against any party to the extent of the full cost of all benefits provided by this *policy*. We may proceed against any party with or without the *member's* consent.

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

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

1. To fully cooperate with us in order to obtain information about the *loss* and its cause.
2. To immediately inform us in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.
3. To include the amount of benefits paid by us on behalf of a *member* in any claim made against any *third party*.
4. To give us 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 *policy* (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 to us as reimbursement for the full cost of all benefits associated with *third party* injuries provided by this *policy* (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 *member* in connection with the *loss* equal to the benefit amount we have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect our rights.
    d. Are entitled to all of the rights of the *member* against any *third party* to the extent of the benefits paid on the *member's* behalf.
    e. May assert the right of reimbursement independently of the *member*.

7. To take no action that prejudices our reimbursement rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this *policy*.
8. To sign, date, and deliver to us any documents we request that protect our reimbursement rights.
9. To not settle any claim or lawsuit against a *third party* without providing us with written notice of the intent to do so.
10. To reimburse us from any money received from any *third party*, to the extent of benefits we paid for the *illness* or *injury*, whether obtained by settlement, judgment or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
11. That we may reduce other benefits under the *policy* by the amounts a *member* has agreed to reimburse us.

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

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

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

Coordination of Benefits

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

It is a contractual provision of a majority of health benefit policies. 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 health care including *deductible amounts*, *copayment amounts and coinsurance amounts*, when the item is covered in full or in part under any of the plans covering the person, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

"Plan", as used in this section, is a form of coverage with which coordination is allowed.

The term "plan" includes:

1. Group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured or self-funded. This includes group HMO insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.
2. *Hospital*, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required or provided by law, except Medicaid.

The term "plan" does not include:

1. Blanket school accident coverage that covers elementary, high-school or college students for accident only, including athletic injuries, either on a 24-hour basis or on a to-and-from school basis.
2. Individual or family insurance contracts, direct payment *subscriber* contracts, coverage through health maintenance organizations (HMO's) or coverage under other prepayment, group practice and individual practice plans.

"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 decides 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 1-6 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 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 policyholder, 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 *member* may continue to be excess to such basic benefits.

The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

1. If the person receiving benefits is the *member* and is only covered as an *eligible dependent member* under the *other plan*, this *policy* will be primary.
2. Subject to State Statues: Social Security Act of 1965, as amended makes Medicare secondary to the plan covering the person as a *dependent member* of an active employee, the order of benefit determination is:
   a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
   b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the *other plan* does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the *other plan* will determine which plan is primary.
3. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
   a. The plan of the parent who has custody will be primary.
   b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
   c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.
4. If the person receiving services is covered under one plan as an active employee or *member* (e.g., not laid-off or retired) or as the *spouse* or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the *spouse* or child of such a laid-off or retired employee, the plan that covers such person as an active employee or *spouse* or child of an active employee will be primary. If the *other plan* does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
5. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination
When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed our maximum available benefit for each

covered service. Also, the amount we pay will not be more than the amount we would pay if we were primary. As each claim is submitted, we will determine our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

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 *policy* 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 *policy* and *other plans* covering the person claiming benefits. We need not tell or get the consent of any person to do this.

Claims

Notice of Claim and Claim Forms
We must receive written notice of a claim within 60 days of the date the *loss* began or as soon as reasonably possible in order for benefits to be paid. Upon receipt of notice of claim, we will provide you with the *proof of loss* forms within 15 calendar days. In addition, claim forms to submit *proof of loss* are available at Ambetter.WellCareKY.com under "For Members," "Forms and Materials".

Proof of Loss
We must receive written *proof of loss* within 90 days of the *loss* or as soon as is reasonably possible. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

How to Submit a Claim or Proof of Loss
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 amount, copayment amount* or *coinsurance amount* 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 a copy of the *member* reimbursement claim form, which is posted at Ambetter.WellCareKY.com under "For Members," "Forms and Materials". If such forms are not available on that website, we will, upon receipt of a notice of claim, furnish such form to you within 15 days. Send all the documentation to us at the following address:

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

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

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

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

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

Time for Payment of Claims
Benefits will be paid within 30 days (60 days for organ transplant claims) 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 (60 days for organ transplant claims) after our receipt of all requested information.

In the event we do not process your claim within 30 days (60 days for organ transplant claims), you will be entitled to interest at the rate of 12 percent per year, from the 30th (or 60th for organ transplant claims) day after the receipt of all claim information until the date payment is actually made.

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

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

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

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 the entire period of travel, including the first 90 days.

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

Foreign claims must be submitted with the Member Reimbursement Medical Claim Form, along with all requested documents as detailed on the claim form. All forms and *member* resources are available at Ambetter.WellCareKy.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 we have 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 policy* at the time of travel. If services are deemed as a true medical emergency, the *member* will be issued reimbursement payment for any eligible incurred costs, minus *member cost share* obligation.

Assignment
You may assign the right to payment for benefits as provided for in this *policy* to a *hospital* or health care provider, and we will provide payment to such *hospital* or health care provider if:

1. You assign your health insurance benefits to the *hospital* or health care provider in writing; and
2. We approve the assignment in writing.

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

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

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

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

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

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

Upon request by the custodial parent, we will:

1. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions, and limitations of the *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 and Autopsy
We shall have the right and opportunity to examine a *member* while a claim is pending or while a dispute over the claim is pending. These examinations are made at our expense and as often as we may reasonably require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law.

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

Time Limit on Certain Defenses
After three years from the date of issue of this *policy* no misstatements, except fraudulent misstatements, made by the applicant in the enrollment application for the *policy* shall be used to void the *policy* or to deny a claim for *loss* incurred or disability (as defined in the *policy*) commencing after the expiration of the three year period.

Change of Beneficiary
Unless you make an irrevocable designation of beneficiary, you have the right to change your beneficiary at any time and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this *policy* or to any change of beneficiary or beneficiaries or to any other changes in this *policy*.

Complaint and Appeal Procedures

Internal Review

Complaints/Grievances
Ambetter of Kentucky has a *complaint* procedure which allows you the opportunity to resolve any issues that do not relate to *adverse benefit determinations,* which would be subject to the *appeals* process explained herein. The *complaint* process is voluntary and is available for review of the policy, quality of care or quality of service issues that affect you.

Complaints are normally, but not limited to, the following concerns:

1. Availability, delivery or quality of health care services;
2. Matters pertaining to the contractual relationship between a *member* and us;
3. Matters pertaining to the contractual relationship between a health care provider and us; and
4. *Policy* reformation or amendment disputes.

Filing a Complaint
Complaints may be filed by a *member*, the *member's* authorized representative or a provider acting on behalf of a *member*. *Complaints* may be filed orally by calling 1-833-705-2175 (Relay 711), but must be followed up in writing by mailing a letter or the Complaint and Appeal Form from our website, along with copies of any supporting documents to

Ambetter of Kentucky
Attn: Grievance and Appeals Department
12515-8 Research Blvd., Suite 400
Austin, TX 78759
Fax: 1-833-886-7956

When a *complaint* is filed by anyone other than the *member*, unless otherwise permitted under applicable law, informed consent is required and the *complaint* should include an informed consent form stating that the *member* has given consent to act on his or her behalf. If disclosure of health care information or medical *records* is prohibited by law, such health care information or medical *records* may be withheld from an authorized representative, including information contained in its resolution of the *grievance*. However, a *complaint* 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.

Within five business days of when we receive a *complaint*, we will send a written acknowledgment confirming receipt. We will issue a written resolution to you and your authorized representative, if applicable, within 30 calendar days after receiving the *complaint*. We may extend the timeframe for disposition of a *complaint* for up to 14 calendar days if the *member* requests the extension or if the *member* gives consent.

Appeals
When we deny a claim for a treatment or service, a claim for plan benefits you have already received (*post-service claim* denial) or we deny your request to authorize treatment or service (pre-service denial), our decision is known as an *adverse benefit determination*. You, your *physician* or authorized representative can request an *appeal* of our decision. If we rescind your coverage or deny your application for coverage, you may also *appeal* our decision. When we receive your *appeal*, we are required to review our own decision.

Appeals must be filed in writing by you, your authorized representative or your provider acting on your behalf by filing the Grievance and Appeals form from our website or by mailing a written *appeal* along with copies of any supporting documents to:

Ambetter of Kentucky
Attn: Grievances and Appeals Department
12515-8 Research Blvd., Suite 400
Austin, TX 78759

Right to Participate
A *member*, the *member's* authorized representative or your provider acting on your behalf who has filed an *appeal* has the right to submit written comments, documents, *records* and other information to the Grievance and Appeals Department. The *member* or *member's* authorized representative is entitled to request a copy of the documentation reviewed by the Grievance and Appeals Department in making its determination. The *member* must submit questions or comments to the Grievance and Appeals Department in writing within a period of time provided in the notice to the *member* of the *appeals* process.

Continuing Coverage
We cannot terminate your benefits until your *appeal* rights have been exhausted. However, if the plan's decision is ultimately upheld, you may be responsible to pay any outstanding claims or reimbursing the plan for claim payments it made during the time of the *appeals*.

Cost and Minimums for Appeals
There is no cost to you to file an *appeal* and there is no minimum amount required to be in dispute.

Rescission of Coverage
If we rescind your coverage, you may file an *appeal* of that determination. We cannot terminate your benefits until your *appeal* rights have been exhausted. Since a *rescission* means that no coverage ever existed, if our decision to rescind is upheld, you will be responsible for payment of all claims for your health care services.

Time Limits for Filing an Appeal
You or your authorized representative must file the internal *appeal* within 180 calendar days of the receipt of the notice of denial (an *adverse benefit determination*). Failure to file within this time limit may result in the company's declining to consider the *appeal*.

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

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

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

Resolution Timeframes
Appeals will be resolved and we will notify you in writing with the *appeal* decision within the following timeframes:

1. *Post-service claim*: within 30 calendar days after receipt of the request for internal *appeal*; or
2. *Pre-service claim*: within 3 days for urgent claims and 30 calendar days for non-urgent claims after receipt of the request for internal *appeal*.

In general, we may seek your approval to extend the time for providing a decision for 14 calendar days after the expiration of the initial period or if we determine that such an extension is necessary for reasons beyond our control. There is no provision for extensions in the case of claims involving urgent care or *expedited appeals*.

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

1. The *member* will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The plan will give the *member* 10 calendar days to respond to the new information before making a determination, unless the State turnaround time for response is due in less than 10 days. If the State turnaround time is less than 10 days, the *member* will have the option of delaying the determination for a reasonable period of time to respond to the new information; or
2. The *member* will receive from us, as soon as possible, any new or additional medical rationale considered by the reviewer. We will give the *member* 10 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 10 days. If the State turnaround time is less than 10 days, the *member* will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.

Emergency Medical Services
If we deny a claim for an emergency medical service, your *appeal* will be handled as an *expedited appeal*. We will advise you at the time we deny the claim that you can file an *expedited appeal*. If you have filed for an *expedited appeal*, you may also file for an expedited external review (see "Simultaneous urgent claim, *expedited appeal* and external review").

Expedited Appeal
Expedited appeal means *appeal* 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 *appeal*.

An *expedited appeal* may be submitted orally or in writing. If submitted orally, the request must be follow up by a brief written *appeal*. All necessary information, including our determination on review, will be transmitted between the *member* and us by telephone, facsimile or other available similarly expeditious method. An *expedited appeal* shall be resolved as expeditiously as the *claimant*'*s* health condition requires, but not more than 72 hours after receipt of the *appeal*.

If the *expedited appeal* involves an adverse determination with respect to a concurrent review of an urgent care request, the service shall be continued until the *member* or *member's* authorized representative has

been notified of the determination or until the health care provider determines that the urgent care is no longer appropriate or necessary. This does not apply to requests for extensions.

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

Simultaneous Expedited Appeal and External Review
You or your authorized representative, may request an *expedited appeal* and an expedited external review (see External Review provision) if both the following apply:

1. You have filed a request for an *expedited appeal*; and
2. After a final *adverse benefit determination*, if either or the following applies:
    a. Your treating *physician* certifies that the *adverse benefit determination* involves a medical condition that could seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, if treated after the timeframe of a standard external review;
    b. The final *adverse benefit determination* concerns an admission, availability of care, continued stay or health care service for which you received *emergency services*, but has not yet been discharged from a facility.

Written Appeal Response
Appeal response letter (*final adverse determinations*) will be written in a manner to be understood by you and the notification shall include the specific reasons for the denial, determination or initiation of disenrollment.

Our written *final adverse determination* of the *appeal* will include:

1. The disposition of and the specific reason or reasons for the decision in clear terms and the medical rationale for the decision, if applicable
2. Any corrective action taken on the *appeal*;
3. The titles and qualifying credentials of the persons involved in making the decision;
4. A statement of the reviewer's understanding of the issues;
5. Reference to the evidence or documentation used as the basis for the decision
6. Reference to the specific plan or *policy* provision on which the determination is based;
7. A statement that the *member* is entitled to receive, upon request and free of charge, reasonable access to and, copies of all documents, *records* and other information relevant to the *member's* issue;
8. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the *adverse benefit 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 benefit determination* and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the *member* upon request;
9. If the *adverse benefit determination* is based on *medical necessity* or *experimental or investigational* 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 *member's* medical circumstances or a statement that such explanation will be provided free of charge upon request;
10. A description of the procedures for obtaining an external review of the *final adverse determination*; and
11. If applicable:
    a. Identification of medical experts whose advice was obtained on behalf of us, without regard to whether the advice was relied upon in making the *adverse benefit determination*;
    b. The date of service;
    c. The health care provider's name;
    d. The claim amount;

e. The diagnosis and procedure codes with their corresponding meanings or an explanation that the diagnosis and/or procedure codes are available upon request;
f. Our denial code with corresponding meaning;
g. A description of any standard used, if any, in denying the claim;
h. A description of the external review procedures, if applicable;
i. The right to bring a civil action under state or federal law;
j. A copy of the form that authorizes us to disclose protected health information, if applicable;
k. That assistance is available by contacting the Kentucky Department of Insurance, if applicable; and
l. A culturally linguistic statement based upon the *member's* county or state of *residence* that provides for oral translation of the *adverse benefit determination*, if applicable.

External Review
An external review is conducted by an *Independent Review Organization* (IRO) that will review the final *appeal* decision and render a decision on whether to uphold or reverse the *adverse benefit determination.* 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.

The *member* will be assessed a fee of $25 for the independent review to be paid to the IRO for the external review. This fee may be waived if the IRO determines that the fee would create a financial hardship for the *member*. The fee will be refunded if the external review results in a decision favorable to the *member*. If the *member* submits multiple external review requests in one year, the total cost of all combined reviews will not exceed $75.

Applicability/Eligibility
The external review procedures apply to:

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

An external review is available for *appeals* that involve 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.

External Review Procedure
After exhausting the internal review process, the *claimant* has four months to make a written request to the Grievance and Appeals Administrator for external review after the date of receipt of our internal response.

1. The internal *appeal* process must be exhausted before the *claimant* may request an external review unless the *claimant* files a request for an expedited external review at the same time as an internal expedited *appeal* or we either provide a waiver of this requirement or fail to follow the *appeal* process;
2. We must allow a *claimant* to make a request for an expedited external review with us at the time the *claimant* receives:
    a. An *adverse benefit determination* if the determination involves a medical condition of the *claimant* for which the timeframe for completion of an internal *expedited appeal* would seriously jeopardize the life or health of the *claimant* or would jeopardize the *claimant's* ability to regain maximum function and the *claimant* has filed a request for an internal *expedited appeal*; and
    b. A final internal *adverse benefit determination*, if the *claimant* has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the *claimant* or would jeopardize the *claimant's* ability to regain maximum

function or if the final internal *adverse benefit determination* concerns an admission, availability of care, continued stay or health care item or service for which the *claimant* received *emergency services*, but has not been discharged from a facility; and

3. *Claimants* may request an expedited external review at the same time the internal *expedited appeal* is requested (see procedures below).

External Review Process

1. We have five business days (immediately for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether:
    a. The individual was a *member* at the time the item or service was requested;
    b. The service is a *covered service* under the *claimant's* health plan but for the plan's *adverse benefit determination* with regard to medical necessity *experimental or 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) after completion of the preliminary review, we will notify the *claimant* in writing as to whether the request is complete but not eligible for external review and the reasons for its ineligibility or, if the request is not complete, the additional information needed to make the request complete;
3. We must allow a *claimant* to perfect the request for external review within the four month filing period or within the 48-hour period following the receipt of notification;
4. We will assign an IRO on a rotating basis from our list of contracted IROs;
5. Within six business days after the date of assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO.

    Note: For expedited, after assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method;

6. If we fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the *adverse benefit determination*;
7. Within three business days, the assigned IRO will timely notify the *claimant* in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the *claimant* may submit in writing additional information to the IRO to consider;
8. Upon receipt of any information submitted by the *claimant*, the IRO must forward the information to us within one business day;
9. Upon receipt of the information, we may reconsider our determination. If we reverse our *adverse benefit determination*, we must provide written notice of the decision to the *claimant* and the IRO within one business day after making such decision. The external review would be considered terminated;

    Within 21 calendar days 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 us. An extension of up to 14 calendar days may be allowed if the claimant and the *insurer* are in agreement.

10. Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, we will approve the *covered service* that was the subject of the *adverse benefit determination*.

Expedited External Review

An expedited external review may be submitted orally or in writing. All necessary information will be transmitted between the *claimant* and us by telephone, facsimile or other available similarly expeditious

method and given by us to the IRO.

We will allow a *member* to make a request for an expedited external review with the plan at the time the *member* receives:

a. An *adverse benefit determination* if the determination involves a medical condition of the *member* for which the timeframe for completion of an internal expedited *appeal* would seriously jeopardize the life or health of the *member* or would jeopardize the *member's* ability to regain maximum function and the *member* has filed a request for an internal expedited *appeal*; and

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

An expedited external review shall be resolved as expeditiously as the *member's* health condition requires but not more than 24 hours after receipt of the request for expedited external review. An extension of up to 24 hours may be allowed if the *member* and the *insurer* or its designee agree.

Complaint and appeal filing and key communication timelines:

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard Complaint	N/A	5 Business Days	30 Calendar Days	14 Calendar Days
Standard Pre-Service Appeal	180 Calendar Days	5 Business Days	Urgent Claims: 24 hours Non-Urgent Claims: 5 Calendar Days	N/A
Expedited Pre-Service Appeal	180 Calendar Days	N/A	24 Hours	N/A
Standard Post-Service Appeal	180 Calendar Days	5 Business Days	30 Calendar Days	14 Calendar Days
External Review	4 Months	N/A	21 Calendar Days	14 Calendar Days
Expedited External Review	4 Months	Immediately	24 Hours	24 Hours

General Provisions

Entire Policy
This *policy,* with the enrollment application, the *Schedule of Benefits*, and any amendments and/or riders, is the entire *policy* 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.

No change in this *policy* shall be valid until approved by an executive officer and unless such approval is endorsed hereon or attached hereto.

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

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

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

Repayment for Fraud, Misrepresentation or False Information
During the first two years a *member* is covered under the *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 State Laws
Any part of this *policy* in conflict with the laws of Kentucky on this *policy's effective date* or on any premium due date is changed to conform to the minimum requirements of Kentucky state law.

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

We protect all oral, written and electronic PHI. We follow the Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. We are required to notify you about these practices every year. This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. If you need more

information or would like the complete notice, please visit https://Ambetter.WellCareKy.com/privacy-practices.html or call Member Services at 1-833-705-2175 (Relay 711).

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

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

Statement of Non-Discrimination

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

Ambetter from WellCare of Kentucky:

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

If you need these services, contact Ambetter from WellCare of Kentucky at 1-833-705-2175 (TTY 711).

If you believe that Ambetter from WellCare of Kentucky has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a *grievance* with: Ambetter from WellCare of Kentucky, Attn: Appeals & Grievances PO Box 10341 Van Nuys CA, 91410, 1-833-705-2175 (TTY: 711), Fax 1-833-886-7956.

You can file a *grievance* in person or by mail, fax or email. If you need help filing a *grievance*, Ambetter from WellCare of Kentucky is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

Declaración de no discriminación

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

Ambetter de WellCare of Kentucky:

- 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 de WellCare of Kentucky, 1-833-705-2175 (TTY 711).

Si cree que Ambetter de WellCare of Kentucky 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 from WellCare of Kentucky, Attn: Appeals and Grievances, PO Box 10341 Van Nuys CA, 91410, 1-833-705-2175 (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 de WellCare of Kentucky 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*.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from WellCare of Kentucky, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-705-2175 (TTY 711).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from WellCare of Kentucky, 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 1-833-705-2175 (TTY 711).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from WellCare of Kentucky 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 1-833-705-2175 (TTY 711) an.
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from WellCare of Kentucky, 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 1-833-705-2175 (TTY 711).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حولAmbetter from WellCare of Kentucky ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ (TTY 711) 1-833-705-2175.
Serbo-Croatian:	Ako Vi, ili neko kome pomažete, imate pitanja u vezi Ambetter from WellCare of Kentucky, imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-833-705-2175 (TTY 711).
Japanese:	Ambetter from WellCare of Kentucky について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-833-705-2175 (TTY 711) までお電話ください。
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from WellCare of Kentucky, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez-le 1-833-705-2175 (TTY 711).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from WellCare of Kentucky 에 관해서 질문이 있다면 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-833-705-2175 (TTY 711) 번으로 전화하십시오.
Pennsylvania Dutch:	Vann du, adda ebbah's du am helfa bisht, ennichi questions hott veyyich Ambetter from WellCare of Kentucky, dann hosht du's recht fa hilf greeya adda may aus finna diveyya in dei shprohch un's kosht nix. Fa shvetza mitt ebbah diveyya, kawl 1-833-705-2175 (TTY 711).
Nepali:	यदि तपाई स्वयं वा तपाईंले मद्दत गर्दै गरेको व्यक्तिसँग Ambetter from WellCare of Kentucky को बारेमा प्रश्नहरू छन् भने तपाईंसँग तपाईंलाई कुनै खर्च नलाग्ने गरी आफ्नो भाषामा मद्दत तथा जानकारी प्राप्त गर्ने अधिकार हुन्छ । दोभाषेसँग कुरा गर्नको लागि 1-833-705-2175 (TTY 711) मा फोन गर्नुहोस् ।
Cushite:	Isin yookan namni biraa isin deeggartan Ambetter from WellCare of Kentucky irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-833-705-2175 (TTY 711) tiin bilbilaa.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Ambetter from WellCare of Kentucky вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-833-705-2175 (TTY 711).
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from WellCare of Kentucky, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-833-705-2175 (TTY 711)**.**
Bantu:	Niba wowe cyangwa undi muntu wese uri gufasha yaba afite ikibazo kijyanye na Ambetter from WellCare of Kentucky, ufite uburenganzira bwo guhabwa amakuru mu rurimi wunva utishyuye. Kugira ngo uvugane n'umusobanuzi, Hamagara 1-833-705-2175 (TTY 711).