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of North Carolina Inc.

2023 Evidence of Coverage Ambetter +Adult Vision+Adult Dental

AmbetterofNorthCarolina.com

77264NC002-2023

Ambetter of North Carolina Inc.
Name of Product

Home Office: 10101 David Taylor Drive, Suite 300, Charlotte, NC 28262

Individual Member HMO Policy

Ambetter of North Carolina Inc. is a health maintenance organization (HMO), organized under the laws of the State of North Carolina, providing health care coverage for *members*. In this *policy,* the terms "you", or "your", will refer to the *member* or any *dependents* enrolled in this *policy*. The terms "we," "our," or "us" will refer to *Ambetter* of North Carolina Inc.

This *policy* is a closed panel *network* HMO. This means that services rendered by *non-network providers* will not be covered except in limited situations described in the *eligible expense* definition, found on page 15 of the *policy*.

This *policy* is a legal contract between you and us. Read your *policy* carefully.

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

Annually, we must file this product, the cost share, and the rates associated with it for approval. Guaranteed renewable means that your plan will be renewed into the subsequent year's approved product on the anniversary date unless terminated earlier in accordance with *policy* terms. You may keep this *policy* (or the new *policy* you are mapped to for the following year) in force by timely payment of the required premiums. In most cases, you will be moved to a new *policy* each year, 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 a new *policy* at the same metal level with a similar type and level of benefits, to residents of the state where you then live; (2) we withdraw from the *service area*; or (3) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *policy* benefits.

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

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

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.

Important Cancellation Information – Please read the provision entitled, "Termination," found on page 73 of the *policy*.

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 provider*. You do not need a referral from your *network PCP* for: 1) obstetrical or gynecological treatment from a *network* obstetrician or gynecologist; 2) *network* pediatrician; or 3) *network provider* who has been designated as your *network PCP* to treat your serious or chronic degenerative, disabling, or life-threatening disease or condition. Benefits may be reduced or not covered if the requirements are not met. Please refer to the *Schedule of Benefits* and the Prior Authorization Section.

TEN DAY RIGHT TO RETURN POLICY

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

Ambetter of North Carolina Inc.

Catherine M. Campbell
Plan President

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Introduction

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

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

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

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

How to Contact Us
Ambetter of North Carolina Inc.
Attn: *Ambetter* Department
10101 David Taylor Drive,
Suite 300
Charlotte, NC 28262

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST
Member Services 1-833-863-1310
Relay 711
Fax 1-833-537-2330
Emergency 911
24/7 Nurse Advice Line 1-833-863-1310

Interpreter Services
Ambetter of North Carolina Inc. has a free service to help our *members* who speak languages other than English. These services ensure that you and your *provider* can talk about your medical or *behavioral health* concerns in a way that is most comfortable for you.

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

To arrange for interpretation services, please call Member Services at 1-833-863-1310 or for the hearing impaired (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 *provider,* and *medical practitioners*.
3. Providing information to help you become an informed health care consumer.
4. Providing access to *covered services* and our *network providers*.
5. Sharing our expectations of you as a *member*.
6. Providing coverage regardless of age, ethnicity, race, religion, gender, sexual orientation, national origin, physical or mental disability, or expected health or genetic status.

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

You have the right to:

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

11. A current list of *network providers*.
12. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
13. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, ethnicity, race, religion, gender, sexual orientation, national origin, physical or mental disability, or expected health or genetic status.
14. Access *medically necessary* urgent and *emergency services* 24 hours a day and seven days a week.
15. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.
16. Refuse treatment to the extent the law allows without jeopardizing future treatment, and be informed by your provider(s) of the medical consequences. You are responsible for your actions if treatment is refused or if the *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.
17. Select your *PCP* within the *network*. You also have the right to change your *PCP* or request information on *network providers* close to your home or work.
18. Know the name and job title of people giving you care. You also have the right to know which *provider* is your *PCP*.
19. An interpreter when you do not speak or understand the language of the area.
20. A second opinion by a *network provider*, if you want more information about your treatment or would like to explore additional treatment options.
21. Make advance directives for health care decisions. This includes planning treatment before you need it.
22. Determine what actions should be taken regarding your health if you are no longer able to make decisions for yourself because of *illness* or because you are incapacitated. You have the right to have your wishes known by completing advance directives forms. Advance directive forms are forms you can complete to protect your rights for medical care. It can help your *PCP* and other *providers* understand your wishes about your health. Advance directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself. Examples of advance directives include:
    a. Living Will;
    b. Health Care Power of Attorney; 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 entire *policy*.
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 *provider* 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 *provider*, and call the *provider'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 *provider*. You may change your *PCP* verbally or in writing by contacting our Member Services Department.
7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
8. Follow the treatment plans and instructions for care that you have agreed on with your health care professionals and *provider*.

9. Tell your health care professional and *provider* if you do not understand your treatment plan or what is expected of you. You should work with your *PCP* to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.
10. Follow all *policy* guidelines, provisions, policies, and procedures.
11. Use any *emergency* room only when you think you have a medical *emergency*. For all other care, you should call your *PCP*.
12. When you enroll in this coverage, give all information about any other medical coverage you have. If, at any time, you get other medical coverage besides this coverage, you must tell the entity with which you enrolled.
13. Pay your monthly premiums, *deductible amounts, copayment amounts*, and *coinsurance amounts* on time.
14. Notify us of any enrollment related changes that would affect your *policy* within 60 days of the event. Enrollment related changes include the following: birth of a child, adoption, marriage, divorce, change of address, adding/removing a dependent, *spouse*/domestic partner becomes eligible under a different insurer, enrollment changes 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 www.AmbetterofNorthCarolina.com. We have plan *providers*, *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, languages spoken and whether or not they are currently accepting new patients. Your search will produce a list of *providers* based on your search criteria and will give you other information such as name, address, phone number, office hours, and specialty and board certifications.

At any time, you can request a copy of the provider directory at no charge by calling Member Services at 1-833-863-1310 (Relay 711). In order to obtain benefits, you may designate a *primary care physician* (*PCP*) for each *member.* We can help you pick a *PCP*. We can make your choice of *PCP* effective on the next business day.

Call the *PCP's* office if you want to make an appointment. If you need help, call Member Services at 1-833-863-1310 (Relay 711). We will help you make the appointment.

Member Identification Card
We will mail you a *member* identification card after we receive your completed enrollment materials and you have paid your initial premium payment. This card is proof that you are enrolled in the *Ambetter* of North Carolina Inc. plan. You need to keep this card with you at all times. Please show this card every time you go for any service under the *policy*.

The *member* identification card will show your name, *member* identification number, 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 1-833-863-1310 (Relay 711). We will send you another card. A temporary identification card can be downloaded from www.ambetterofnorthcarolina.com.

Website
Our website can answer many of your frequently asked questions and has resources and features that make it easy to get quality care. Our website can be accessed at ambetterofnorthcarolina.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 *primary care provider*.

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 Institute of Medicine (IOM) priorities. To help promote safe, reliable, and quality health care, our programs include:

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Providing programs and educational items about general health care and specific diseases.

3. Sending reminders to *members* to get annual tests such as a physical exam, cervical cancer screening, breast cancer screening, and immunizations.
4. A Quality Improvement Committee which includes *network providers* to help us develop and monitor our program activities.
5. Investigating any *member* concerns regarding care received.

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

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

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

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

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

Definitions

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

Wherever used in this *policy*:

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

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

Advance premium tax credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Health Insurance Marketplace. *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 premiums each month, up to the 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 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 denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any *utilization review*, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be *experimental or investigational* or not *medically necessary* or appropriate; and (ii) In the case of a plan providing disability benefits, the term "*adverse benefit determination*" also means any *rescission* of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the *rescission*, there is an adverse effect on any particular benefit at that time). For this purpose, the term "*rescission*" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. An *adverse benefit determination* includes a *non-certification*.

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

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

Please note, if you receive services from a *non-network provider*, you may be responsible for the difference between the amount the *provider* charges for the service (*billed amount*) and the *allowed amount* that we pay. However, you will not be responsible for *balance billing* for unanticipated out-of-*network* care that is otherwise covered under your plan and that is provided by *a non*-network *provider* at an in-*network* facility, unless you gave informed consent before receiving the services. You also will not be responsible for *balance billing* for *emergency services* rendered 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 means *Ambetter* of North Carolina Inc., a health maintenance organization (HMO), which is organized under the laws of the State of North Carolina, providing health care coverage for *members*.

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://www.ambetterofnorthcarolina.com/health-plans/our-benefits/ambetter-telehealth.html.

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

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

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

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

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

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

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.
Autologous bone marrow transplant or *ABMT* means a procedure in which the bone marrow infused is derived from the same person who is the transplant recipient and includes peripheral blood stem cell transplants.

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

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

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

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

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

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, 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 provider*.

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

Complaint means any expression of dissatisfaction expressed to the insurer by the claimant, or a claimant's *authorized representative*, about an insurer or its *providers* with whom the insurer has a 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, *provider* prescribed rest during the period of *pregnancy*, morning sickness, and conditions of comparable severity associated with management of a difficult *pregnancy*, and not constituting a medically classifiable distinct complication of *pregnancy*.
2. An *emergency* cesarean section or a *non-elective cesarean section*.

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

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

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

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

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

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

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

Creditable coverage means accepted health insurance cover carried prior to *Ambetter's* coverage which can be group health insurance, an employee welfare benefit plan to the extent that the plan provides medical care to employees and/or their dependents directly or through insurance, reimbursement, or otherwise, individual health insurance, short-term limited duration health insurance coverage, public health plan, Children's Health Insurance Program (CHIP), Medicare, Medicaid, and any other coverage defined as *creditable coverage* under state or federal law. *Creditable coverage* does not include coverage consisting solely of excepted benefits.

Custodial care means the treatment designed to assist a *covered person* with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from 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, sanatoria 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 service expenses* before we will pay benefits. For family coverage, there is a family *deductible amount* which is two times the individual *deductible amount*. Both the individual and the family *deductible amounts* are shown in the *Schedule of Benefits*.

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

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

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

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

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

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

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

Eligible child means the child of 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 or your *spouse* or domestic partner; or
6. A stepchild.

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

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

1. For *network providers*: When a *covered service* is received from a *network provider*, the *eligible expense* is the contracted fee with that *provider*.
2. For *non-network providers,* unless otherwise required by Federal or North Carolina 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 reimbursement as determined by us and as required by applicable law. *Member cost share* will be calculated from the recognized amount based upon applicable law. You should not be *balance billed* for the difference between the amount we pay and the provider's charges, but you may be subject to *cost-sharing*

obligations. If you are balance billed in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.

b. When a *covered service* is received from a *non-network* professional *provider* who renders non-*emergency services* at an in-network *facility*, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the *provider* as payment in full. If the *provider* has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by applicable law, the *eligible expense* is reimbursement as determined by us and as required by applicable law. Unless you receive and sign the necessary written notice and consent document under federal law before the services are provided, you should not be *balance billed* for the difference between the amount we pay and the *provider's* charges, but you may be subject to *cost-sharing* obligations. *Member cost share* will be calculated from the recognized amount based upon applicable law. If you are balance billed in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.
c. When a *covered service* is received from a *non-network provider* because the service or supply is not available from any *network provider* in your *service area* and is not the result of an *emergency*, the *eligible expense* is the negotiated fee, if any, that the *provider* has agreed to accept as payment in full (you will not be billed for the difference between the negotiated fee and the *provider's* charge). If there is no negotiated fee agreed to by the *provider* with us, the *eligible expense* is the greatest of the following: (i) the amount that would be paid under Medicare; (ii) the amount for the *covered service* calculated using the same method we generally use to determine payments for *non-network providers*; or (iii) the contracted amount paid to *network providers* for the *covered service* (if there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts). You should not be *balance billed* by the provider, if you are, please contact Member Services.
d. 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 is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full (you will not be billed for the difference between the negotiated fee and the provider's charge). If there is no negotiated fee agreed to by the provider with us, the *eligible expense* is the greatest of the following: (i) the amount that would be paid under Medicare; (ii) the amount for the *covered service* calculated using the same method we generally use to determine payments for *non-network providers*; or (iii) the contracted amount paid to *network providers* for the *covered service* (if there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts). You should not be balance billed by the provider, if you are, please contact Member Services.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or acute symptoms resulting from or associated with a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

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

Emergency services means health care items and services furnished or required to screen for or treat an *emergency* until the condition is *stabilized*, including prehospital care and ancillary services routinely available to the *emergency* department of a *hospital*.

Services you receive from a *non-network provider* or *non-network facility* after the point your *emergency* medical/*behavioral health* condition is *stabilized* continue to meet the definition of *emergency services* until

(1) you are discharged from the facility, or (2) both of the following circumstances are met, as well as any other criteria required by federal or state law: (a) the *provider* or facility determines you are able to travel using nonmedical transportation or non-*emergency* 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 *provider* services, and supplies and *prescription drugs* charged by that facility. You must notify us or verify that your *provider* has notified us of your admission to a *hospital* within 24 hours or within 24 hours of post-discharge. When we are contacted, you will be notified whether the *inpatient* setting is appropriate, and if appropriate, the number of days considered *medically necessary*. By contacting us, you may avoid financial responsibility for any *inpatient* care that is determined to be not *medically necessary* under your Plan. If your *provider* does not contract with us, you will be financially responsible for any care we determine is not *medically necessary*. Care and treatment provided once you are *medically stabilized* is no longer considered *emergency* care. Continuation of care from a non-participating *provider* beyond that needed to evaluate or *stabilize* your condition in an *emergency* will be covered as a *non-network* service unless we *authorize* the continuation of care and it is *medically necessary*.

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

Expedited appeal means an *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*.
3. A *provider* with knowledge of the claimant's medical condition determines that the *appeal* shall be treated as an *expedited appeal*.

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

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

d. It has *FDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *FDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*

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

Items (3) and (4) above do not apply to phase 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*.

Foster child means a minor over whom a guardian has been appointed by the clerk of superior court of any county in North Carolina or the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction.

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

If no credible scientific evidence is available, then standards based on *physician* specialty society recommendations or professional standards of care may be considered. We reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered service* under the *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.

Generic prescription drug means a drug that has same active ingredient as brand name drug. Food and Drug Administration (FDA) rates *generic prescription drugs* as equivalent to brand name drugs in safety and efficacy. This tier may cover select over-the-counter (OTC's) and branded drug products.

Grievance means a written *complaint* submitted by a *member* (or a *member's authorized representative* or provider acting on the *member's* behalf) about any of the following: (a) *Ambetter's* decisions, policies, or actions related to availability, delivery, or quality of health care services; (b) claims payment; or reimbursement for services; or (c) the contractual relationship between a *member* and *Ambetter.* A written *complaint* submitted about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a *grievance* if the exclusion of the specific service requested is clearly stated in the evidence of coverage. A *grievance* does not include a *non-certification*.

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

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

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 *provider*.

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 *provider,* in accordance with existing *generally accepted standards of medical practice* for the *injury* or *illness* requiring the *home health care.*

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

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

Hospice care program means a coordinated, interdisciplinary program prescribed and supervised by a *provider* to meet the special physical, psychological, and social needs of a *terminally ill member* and those of his or her *immediate family.*

Hospital means an institution that:

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

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

Infertility means the inability after 12 consecutive months of unsuccessful attempts to conceive a child despite regular exposure of female reproductive organs to viable sperm.

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*, *eligible child* (natural, adopted or foster), or siblings of any *member*, or any person 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 abuse* are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

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

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

Maximum out-of-pocket amount means the sum of the *deductible amount*, *prescription drug deductible amount* (if applicable), *copayment amount,* and *coinsurance* percentage of *covered expenses*, as shown in the *Schedule of Benefits*. After the *maximum out-of-pocket amount* is met for an individual, *Ambetter* of North Carolina Inc. pays 100 percent of *eligible expenses* for that individual. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket amount.* Both the individual and the family *maximum out-of-pocket amounts* are shown in the *Schedule of Benefits*.

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

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

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

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

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

Medical practitioner includes but is not limited to a *provider*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of *providers* that are NOT *medical practitioners*, by definition of the *policy:* acupuncturist, speech therapist, occupational therapist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, *emergency* medical technician, social worker, 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 those *covered services* or supplies that are:

1. Provided for the diagnosis, treatment, cure, or relief of a health condition, *illness*, *injury*, or disease; and except as allowed for clinical trials under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes;
2. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, *illness*, *injury*, disease, or its symptoms;
3. Within generally accepted standards of medical care in the community; and
4. Not solely for the convenience of the *member*, the *member's* family, or the *provider*.

For *medically necessary* services, nothing in this definition precludes us from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

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

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

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

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

Necessary medical supplies means medical supplies that are:

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

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

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

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

Network provider(s) means any person or entity that has entered into a contract with *Ambetter* from North Carolina Inc. 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-certification means a determination by *Ambetter* or its designated *utilization review* organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet *Ambetter's* requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of *emergency services* in N.C.G.S. 58-3-190, and the requested service is therefore denied, reduced, or terminated. A "*non-certification*" is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. A "*non-certification*" includes any situation in which *Ambetter* or its designated agent makes a decision about a *member's* condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision.

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 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 an in-*network* facility, as described in the Access to Care section of this *policy*; or
3. Situations otherwise specially described in this *policy.*

Non-preferred prescription drug means a drug that currently does have a generic equivalent, branded drug that is therapeutically equivalent to another branded drug and that we deemed non-preferred or generic product that is therapeutically equivalent to another generic products and we deemed non-preferred.

Ongoing special condition means 1) in the case of an acute *illness*, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm; 2) in the case of a chronic *illness* or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time; 3) in the case of *pregnancy*, *pregnancy* from the start of the second trimester; or 4) in the case of terminal *illness*, an individual has a medical prognosis that the individual's life expectancy is six months or less.

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

Other plan means any plan or *policy* that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, automobile no-fault or medical pay, homeowner insurance medical pay, premises medical pay, nonprofit health service plans, health maintenance organization *subscriber* contracts, self-insured group plans, prepayment plans, and Medicare when the *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 contraceptive services means consultations, examinations, and medical services, provided on an outpatient basis and related to the use of contraceptive methods, to prevent *pregnancy*, which have been approved by the U.S. Food and Drug Administration.

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

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

Pain management program means a program using interdisciplinary teams providing coordinated, goal-oriented services to a *covered person* who has chronic pain that significantly interferes with physical, psychosocial, and vocational functioning, for the purpose of reducing pain, improving function, and decreasing dependence on the health care system. A *pain management program* must be individualized and provide physical *rehabilitation*, education on pain, relaxation training, and medical evaluation.

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

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

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

Prospective claim means any claim for benefits for medical care or treatment that has not yet been provided and requires the approval of the plan in advance of the claimant obtaining the medical care.

Preferred brand prescription drug means a drug that currently does not have a generic equivalent or a branded drug that is therapeutically equivalent to another branded drug and that we deemed preferred.

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

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

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

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

Primary care physician (PCP) means a *provider* who gives or directs health care services for you. *PCPs* include internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), Physician Assistants (PA), obstetrician gynecologist (OB-GYN), and pediatricians or any other practice allowed by us. A *PCP* supervises, directs, and gives initial care and basic medical services to you and is in charge of your ongoing care.

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

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

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

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

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

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

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

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

Rehabilitation licensed practitioner means, but is not limited to, a *provider*, 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. *Rehabilitation therapy* means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

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

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

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

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

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

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

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

Service area means a geographical area, made up of counties, where we have been authorized by the State of North Carolina to sell and market our health plans. Those counties are: Alexander, Alleghany, Bladen, Caswell, Cumberland, Davidson, Davie, Durham, Forsyth, Franklin, Granville, Guilford, Harnett, Hoke, Iredell, Johnston, Lee, Montgomery, Moore, Orange, Person, Randolph, Richmond, Robeson, Sampson, Scotland, Stokes, Vance, Wake, Warren, Wilkes and Yadkin. You can receive precise *service area* boundaries from our website or our Member Services department.

Sexual dysfunction means any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.

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

1. Is licensed as a *hospital*, *skilled nursing facility*, or *rehabilitation facility* by the state in which it operates;
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *provider* 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 *provider*; 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.

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

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

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

Specialty prescription drug means drugs used to treat complex, chronic conditions that may require special handling, storage, or clinical management.

Spouse means the person to whom you are lawfully married.

Stabilize means medical care appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the Health Care Financing Administration ("HCFA") interpretative guidelines, policies, and regulations pertaining to responsibilities of *hospitals* in *emergency* cases (as provided under the *Emergency* Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. 1395dd), including *medically necessary* services and supplies to maintain stabilization until the person is transferred to an appropriate setting.

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

Substance use* or *substance use disorder means a disorder that affects a person's brain and behavior, leading to an inability to control his/her use of substances (e.g., alcohol, medications and legal or illegal drug s). 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 *provider* while the *member* is under general or local anesthesia.

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

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

Surveillance tests for ovarian cancer means annual screening using:

1. CA-125 serum tumor marker testing;
2. Transvaginal ultrasound; and/or
3. Rectovaginal Pelvic examination.

Telehealth services means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, *care management*, and self-management of a patient's health care while the patient is at the originating site and

the *provider* for *telehealth* is at a distant site. *Telehealth services* includes synchronous interactions and asynchronous store and forward transfers.

The term does not include the delivery of health care services by use of the following:
1. A telephone transmitter for trans-telephonic monitoring; or,
2. A telephone or any other means of communication for the consultation from one *provider* to another *provider*.

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 *provider* 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 or* 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, which are determined not to be effective for treatment of the medical condition, or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from *well-conducted randomized controlled trials* or *well-conducted cohort studies* in the prevailing published peer-reviewed medical literature.
1. *"Well-conducted randomized controlled trials"* means that two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.
2. *"Well-conducted cohort studies"* means patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

Urgent care center means a facility, not including a *hospital emergency* room or a *provider's* office, that provides treatment or services that are required:
1. To prevent serious deterioration of a *member's* health; and
2. As a result of an unforeseen *illness, injury,* or the onset of acute or severe symptoms.

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

Dependent Member Coverage

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

1. The date you became covered under this *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; or
5. The date that a *foster child* is placed with you or your *spouse* and you or your *spouse* are appointed as guardian or custodian of that *foster child* and have assumed the legal obligation for total or partial support of the *foster child* with the intent that the *foster child* reside with you or your *spouse* on more than a temporary or short-term basis.

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

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

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 child's date of birth. If notice of the newborn is given to us by the Health Insurance Marketplace within the 31 days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 days after the birth of the child. If notice is not given within the 31 days from birth, we will charge an additional premium from the date of birth. If notice is given by the Health Insurance Marketplace within 60 days of the birth of the child, we may not deny coverage of the child due to failure to notify us of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st day after its birth, unless we have received notice by the Health Insurance Marketplace 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 *injury* and *illness* including medically diagnosed congenital defect(s) and *medically necessary* care and treatment of conditions existing prior to the date of *placement.*

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

As used in this provision, *"placement"* means the 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.

Coverage for a Foster Child
An *eligible child* legally placed in foster care with you or your *spouse* will be covered from the date of *placement* until the 31st day after *placement*, unless the *placement* is disrupted and the child is removed from your or your *spouse's* custody.

The child will be covered for *loss* due to *injury* and *illness* including medically diagnosed congenital defect(s) and *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 received notification from the Health Insurance Marketplace. The required premium will be calculated from the date of *placement*. Coverage of the child will terminate on the 31st day following *placement*, unless we have received both: (A) Notification of the addition of the child from the Health Insurance Marketplace within 60 days of the *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 physically residing with you or your *spouse*, appointed as guardian or custodian of a *foster child* as long as that guardian or custodian has assumed the legal obligation for total or partial support of the *foster child* with the intent that the *foster child* reside with you or your *spouse* on more than a temporary or short-term basis.

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

Ongoing Eligibility

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

1. The primary *member* residing outside the *service area* or moving permanently outside the *service area* of this plan;
2. The date of termination that the Health Insurance Marketplace provides us upon your request of cancellation to the Health Insurance Marketplace, or if you enrolled directly with us, the date we receive a request from you to terminate this *policy*, or any later date stated in your request;
3. 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*;
4. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or
5. 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 Health Insurance Marketplace (Marketplace) at www.healthcare.gov or 1-800-318-2596. If you enrolled through *Ambetter,* you can contact Member Services at 1-833-863-1310 (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 thirty-first of December the year the dependent turns 26 years of age. All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*.

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

1. Not capable of self-sustaining employment due to mental 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 Health Insurance Marketplace. The open enrollment period begins November 1, 2022 and extends through January 15, 2023. *Qualified individuals* who enroll on or before December 15, 2022 will have an *effective date* of coverage on January 1, 2023.

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

1. A *qualified individual* or dependent experiences a *loss* of *minimum essential coverage*, non-*calendar year* group or individual health insurance coverage, *pregnancy*-related coverage, access to health care services through coverage provided to a pregnant *member*'s unborn child, or medically needed coverage;
2. A *qualified individual* gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order. In the case of marriage, at least one *spouse* must demonstrate having *minimum essential coverage* as

described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage;

3. A *qualified individual* or dependent, who was not previously a citizen, national, or lawfully present individual gains such status; or who is no longer incarcerated or whose incarceration is pending the disposition of charges;
4. A *qualified individual*'s enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or its instrumentalities as evaluated and are determined by the Health Insurance Marketplace;
5. A *member* or dependent adequately demonstrates to the Health Insurance Marketplace that the plan in which he or she is enrolled substantially violated a material provision of its *policy* in relation to the *member*;
6. A *qualified individual*, *member*, or dependent, adequately demonstrates to the Health Insurance Marketplace that a material error related to plan benefits, *service area*, or premium influenced the *qualified individual*'s or *member*'s decision to purchase the *QHP*;
7. A *member* or dependent enrolled in the same plan is determined newly eligible or newly ineligible for *advanced premium tax credits* or has a change in eligibility for cost-sharing reductions;
8. A *qualified individual* or dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for *advanced premium tax credits* based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-2©(3);
9. A *qualified individual*, *member*, or dependent gains access to new *QHPs* as a result of a permanent move, and had *minimum essential coverage* as described in 26 CFR 1.5000A–1(b) for one or more days during the sixty days preceding the date of the permanent move;
10. A *qualified individual* or dependent who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a plan or change from one plan to another one time per month;
11. A *qualified individual* or *member* demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide;
12. A *qualified individual*, *member*, or dependent is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B–2, and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
13. A *qualified individual* or dependent is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 days after the qualifying event; or applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;
14. A *qualified individual* newly gains access to an employer sponsored Individual Coverage Health Reimbursement Arrangement (ICHRA) (as defined in 45 CFR 146.123(b)) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code);
15. At the option of the Health Insurance Marketplace, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a plan through the Health Insurance Marketplace following termination of enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence; or
16. A *qualified individual* or dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions or government subsidies completely cease.

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

If you are currently enrolled in *Ambetter* from North Carolina Inc., please contact Member Services at 1-877-687-1187 (Relay 711) with any questions related to your health insurance coverage.

Coverage Effective Dates for Special Enrollment Periods

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

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

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

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

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

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

Prior Coverage

If a *member* is confined as an *inpatient* in a *hospital* on the *effective date* of this agreement, and prior coverage terminating immediately before the *effective date* of this agreement furnishes benefits for the hospitalization after the termination of prior coverage, then services and benefits will not be covered under this agreement for that *member* until the *member* is discharged from the *hospital* or benefits under the prior coverage are exhausted, whichever is earlier. "Discharge" means a formal release of a *member* from an *inpatient hospital* stay when the need for continued care at an *inpatient* has concluded. Transfers from one *inpatient hospital* to another shall not be considered a discharge. In the case that the prior coverage

terminating immediately before the *effective date*, does not furnish benefits for the hospitalization after the termination, then the "Continuity of Care – Transitional Period: Scheduled Surgery, Organ Transplantation, or Inpatient Care" provision on page 74 will apply.

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

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 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 periods.

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

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

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

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

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

Misstatement of Age

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

Change or Misstatement of Residence

If you change your *residence*, you must notify the Health Insurance of your new *residence* within sixty (60) days of the change. As a result, your premium may change and you may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information.

Misstatement of Tobacco or Nicotine Use

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

Prior Authorization

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

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

Prior Authorization Required
Some *covered service expenses* (medical and *behavioral health*) require *prior authorization*, as more fully detailed in the *Schedule of Benefits*. In general, for services that require *prior authorization*, *network providers* must obtain *authorization* from us prior to providing a service or supply to a *member.* However, there are some *network eligible expenses* for which you must obtain the *prior authorization*.

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

1. Receive a service or supply from a *non-network provider;*
2. Are admitted into a *network* facility by a *non-network provider;* or
3. Receive a service or supply from a *network provider* to which you or your *dependent member* were referred 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 5 days prior to an elective admission as an *inpatient* in a *hospital*, *skilled nursing* or *rehabilitation facility*, residential treatment facility, or *hospice* facility.
2. At least 30 days prior to the initial evaluation for organ transplant services.
3. At least 30 days prior to receiving clinical trial services.
4. Within 24 hours of any *inpatient* admission, including emergent *inpatient* admissions.
5. At least 5 days prior to the start of *home health care*, except those *members* needing *home health care* after *hospital* discharge.

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

1. For urgent concurrent review within 24 hours (1 calendar day) of receipt of the request.
2. For urgent pre-service reviews, within 72 hours (3 calendar days) from date of receipt of request.
3. For non-urgent pre-service reviews within 3 business days of receipt of all necessary clinical information.
4. For post-service or retrospective reviews, within 30 calendar days of receipt of the request.
5. Except in cases of fraud or material misrepresentation, we will be bound by our initial approval of *medically necessary* services or supplies.

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 health insurance identification card before the service or supply is provided to the *member.*

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

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

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

Services from Non-Network Providers
Except for *emergency* medical services, we do not normally cover services received from *non-network providers*. If a situation arises where a *covered service* cannot be obtained from a *network provider* located within a reasonable distance, we may provide a *prior authorization* for you to obtain the service from a *non-network provider* at no greater cost to you than if you went to a *network provider*. If *covered services* are not available from *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.

Covered services received from *non-network providers* will be covered in the following limited situations:
1. When a *covered service* is received from a *non-network provider*, as a result of an *emergency*;
2. When a *covered service* is received from a *non-network provider*, not as a result of an *emergency*, but has been *approved* or *authorized* by us; and
3. When a *covered service* is received from a *non-network provider* because the service or supply is not available from a *network provider* in the *member's service area*, but is not an *emergency*.

In these limited situations, you will be entitled to the *covered services* as described under this *policy* and you will only be responsible for the amount that you would have been charged if you received the *covered services* from a *network provider*.

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

You may not be balance billed for non-*emergency* ancillary services (*emergency* medicine, anesthesiology, pathology, radiology, and neonatology, as well as diagnostic services (including radiology and laboratory services)) received from a *non-network provider* at a *network hospital* or *network* ambulatory facility. Should you receive *covered services* from a *non-network hospital*-based provider at a *network* facility, we will work with the provider on payment of *covered services* to ensure that you are not responsible for an amount in excess of what you would pay to a *network provider*. You should not be billed for amounts in excess of what you would pay to a *network provider*. If you do receive a bill for such amounts, please contact Member Services at 1-833-863-1310 (Relay 711).

Except for *emergency* medical services, we do not normally cover services you may have received from *non-network providers*. In the event our *network* is unable to reasonably meet a *member's* needs, the *member* should seek *prior authorization* for treatment to be provided by *non-network* provider(s) at the *network* facility. If *prior authorization* is obtained, *eligible expenses* for benefits provided by approved *non-network* provider(s) will be covered by *Ambetter* at rates that are comparable to *network* rates. Should you receive a bill from the provider, please contact Member Services at 1-833-863-1310 (Relay 711). We will work directly with the provider to make sure that you are not *balance billed.*

Cost Sharing Features

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

When you, or a covered dependent, receive health care services from a provider, there may be multiple claims for that episode of care. An episode of care means the services provided by a health care facility or provider to treat a condition or an *illness*. Each claim that we receive for services covered under this *policy* is 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 this *policy* and in your *Schedule of Benefits*.

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

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

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

Maximum Out-of-Pocket Amount
You must pay any required *copayments* or *coinsurance* amounts required until you reach the *maximum out-of-pocket amount* shown on your *Schedule of Benefits*. After the *maximum out-of-pocket amount* is met for an individual, we will pay 100 percent of the cost for *covered services*. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket amount*. For the family *maximum out-of-pocket amount*, once a *member* has met the individual *maximum out-of-pocket amount*, the remainder of the family *maximum out-of-pocket amount* can be met with the combination of any one or more *members' eligible expenses*.

Refer to your *Schedule of Benefits* for *coinsurance* percentage and other limitations.

The amount provided or payable will be subject to:

1. Any specific benefit limits stated in the *policy*;
2. A determination of *eligible expenses*; and
3. Any reduction for expenses incurred at a *non-network provider*.

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

Note: Your actual expenses for *covered services* may exceed the stated *coinsurance* or *copayment amount* because actual provider charges may not be used to determine plan and *member* payment obligations.

Non-Network Liability and Balance Billing

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

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

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

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

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 Account. 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* of North Carolina Inc. This entity is not an HSA trustee, HSA custodian or a designated administrator for HSAs. *Ambetter* of North Carolina Inc., its designee, and its affiliates do not provide tax, investment or legal advice to *members*. Refer to IRS guidance for eligible medical expenditures under an HSA.

MEMBERS ARE SOLELY RESPONSIBLE FOR ADHERING TO ALL FEDERAL REGULATIONS AND GUIDELINES CONCERING HSA MAXIMUM 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.

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

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

Access to Care

Primary Care Physician
In order to obtain benefits, you may 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 *Ambetter network specialists*
- Provide any ongoing care you need
- Update your medical record, which includes keeping track of all the care that you get from all of your *providers*
- Treat all patients the same way with dignity and respect
- Make sure you can contact him/her or another provider at all times
- Discuss what advance directive are and file directives appropriately in your medical record.

Adults may designate an OB/GYN as a *network PCP*. You may designate a pediatrician as a *network PCP* for your *dependent member* under 18 years old. 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 our Member Services department.

Members diagnosed with a serious or chronic degenerative, disabling, or life-threatening disease or condition, either of which requires specialized medical care may designate a *specialist*, with expertise in treating the disease or condition, as a *network PCP*. If we determine that the *member's* care would not be appropriately coordinated by the designated *specialist*, we may deny access to that *specialist* as a *network PCP*.

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 a *PCP* in order to receive care from a *specialist provider*. You do not need a referral from your *network PCP* for mental or *behavioral health* services, obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist.

Contacting Your Primary Care Physician (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 1-833-863-1310 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 ID.

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 1-877-687-1187 (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 ambetterofnorthcarolina.com, or by contacting our office at the number shown on your identification card. The change to your *network PCP* of record will be effective no later than 30 days from the date we receive your request.

Referral Required For Maximum Benefits
You do not need a referral from your *network PCP* for: 1) obstetrical or gynecological treatment from a *network* obstetrician or gynecologist; 2) *network* pediatrician; or 3) *network provider* who has been designated as your *network PCP* to treat your serious or chronic degenerative, disabling, or life-threatening disease or condition. For all other *network specialists,* 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. Please refer to the *Schedule of Benefits*.

Network Availability
Your *network* is subject to change upon advance written notice. A *network service area* may not be available in all areas. If you move to an area where we are not offering access to a *network*, please contact Member Services prior to moving. Note that services from *non-network providers* are not covered under this agreement, 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 service expenses* under one benefit provision will not qualify as *covered service expenses* under any other benefit provision of this *policy.*

Non-Emergency Services
If you are traveling outside of the North Carolina *service area*, you may be able to access providers in another state if there is an *Ambetter* plan located in that state. You can locate *Ambetter* providers outside of North Carolina 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 approval for *emergency* care services.

Continuity of Care
Termination of Provider: We will notify you on a timely basis of the termination and of the right to elect continuation of coverage of treatment by the *provider*. You will continue to receive treatment up to 90 days after we notify you of the provider's termination.

Newly Covered *Member*: If you are undergoing treatment from a *provider* for an *ongoing special condition* and are newly covered under this *policy*, we will notify you on your enrollment date of your right to elect to continue treatment with the *provider* currently treating your *ongoing special condition*. You will continue to receive treatment up to 90 days after you enroll in this *policy*.

Transitional Period – Scheduled Surgery, Organ Transplantation, or Inpatient Care: If you had *surgery*, organ transplant, or other *inpatient* care scheduled prior to the *provider* being terminated or your recent enrollment in this *policy*, or if you were listed on an established waiting list as of the date of notice of *provider* termination or enrollment, you will be able to continue to see the *provider* through the date of discharge after completion of the *surgery*, transplant, or other *inpatient* care and through post-discharge *follow-up care* related to the *surgery*, transplant, or other *inpatient* care occurring within 90 days after the date of discharge.

Transitional Period – Pregnancy: If you are in your second trimester of *pregnancy* when your *provider* was terminated or if you are a newly enrolled *member*, you will be able to continue to see the treating *provider* through 60 days of postpartum care.

Transitional Period – Terminal Illness: If you were determined to be *terminally ill* at the time of a *provider's* termination or when you enrolled in this *policy* and the *provider* was treating the terminal *illness* before the date of the termination or enrollment, you will be able to continue to see the treating *provider* for the remainder of your life with respect to care directly related to the treatment of the terminal *illness* or its medical manifestations.

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

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

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

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

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

Major Medical Expense Benefits

We provide coverage for health care services for a *member* or covered dependents when ordered or provided by your *PCP*. Some services require *prior authorization*.

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

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

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

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

Ambulance Service Benefits
Covered service expenses will include ambulance services for local ground transportation, transportation from home, scene of accident, or medical *emergency*:

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

Prior authorization is not required for *emergency* ambulance transportation. Note: Non-*emergency* ambulance transportation requires *prior authorization*. If you receive services from *non-network* ambulance providers, you may be responsible for costs above the allowed charges.
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.

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. Ambulance services provided for a *member's* comfort or convenience.
4. Non-*emergency* transportation excluding ambulances (for example, transport-van, taxi).

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

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

Prior authorization is not required for *emergency* ambulance transportation. Please Note: You should not be balance billed for services from a *non-network* ambulance provider, beyond your cost share, for 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*.

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

Exclusions:
No benefits will be paid for:

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

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

Treatment for an *Acquired Brain Injury* may be provided at a *hospital*, an acute or post-*acute rehabilitation*, *hospital,* an assisted living facility or any other facility at which appropriate services or therapies may be provided. Service means the work of testing, treatment, and providing therapies to an individual with an

Acquired Brain Injury. Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an *Acquired Brain Injury*.

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

1. Has incurred an *Acquired Brain Injury*;
2. Has been unresponsive to treatment; and
3. Becomes responsive to treatment at a later date.

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

Autism Spectrum Disorder Benefits
Ambetter will provide coverage for the screening, diagnosis and treatment of *autism spectrum disorder*. Generally recognized services prescribed in relation to *autism spectrum disorder* by a *provider* or *behavioral health* practitioner in a treatment plan recommended by that *provider* or *behavioral health* practitioner.

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

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

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

Blood
Your benefits cover the cost of transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream. Benefits are provided for the cost of storing a *member's* own blood only when it is stored and used for a previously scheduled procedure.

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

Dialysis Services
Medically necessary acute and chronic dialysis 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 in an in-*network* dialysis facility or peritoneal dialysis in your home from a *network provider* when you qualify for home dialysis.

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

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

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

<u>Durable Medical Equipment</u>
The rental (or, at our option, the purchase) of *durable medical equipment* prescribed by a *provider* 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 IV 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, but are not limited to:

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

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

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

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*.

Exclusions
Non-*covered services,* devices and/or supplies include, but are not limited to:

1. Adhesive tape, band aids, cotton tipped applicators.
2. Arch supports.
3. Doughnut cushions.
4. Hot packs, ice bags.
5. Vitamins (except as provided for under Preventive Care Expense Benefits provision).
6. Med-injectors.
7. Items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

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. Coverage is only for diabetic care only.
10. Devices for correction of positional plagiocephaly.

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, but are not limited to:

1. Orthopedic shoes (except therapeutic shoes for diabetics).
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
3. Standard elastic stockings (except for *members* with diabetes), garter belts, and other supplies not specifically made and fitted (except as specified under the Medical Supplies provision).
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. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per benefit period, as required by the Women's Health and Cancer Rights Act. Maximums for *prosthetic devices*, if any, do not apply.
3. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
4. 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.
5. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
6. Restoration prosthesis (composite facial prosthesis).
7. Wigs (the first one following cancer treatment, not to exceed one per benefit period) when purchased through a participating *provider*.
8. Cochlear implant and bone-anchored hearing aids.

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 (except for *members* with diabetes), garter belts, arch supports, and corsets.
4. Wigs (except as described above following cancer treatment).

Habilitation, Rehabilitation, and Skilled Nursing Facility Expense Benefits
Covered service expenses include services provided or expenses incurred for *habilitation* or *rehabilitation services* (including *cardiac rehabilitation* and pulmonary *rehabilitation*) or confinement in a *skilled nursing facility*, subject to the following limitations:
1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation services* or confinement in a *rehabilitation facility* or *skilled nursing facility* must be determined *medically necessary*.
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *skilled nursing facility* for:
    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    c. Drugs and medicines that are prescribed by a *provider*, filled by a licensed pharmacist, and approved by the U.S. Food and Drug Administration.
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners.*
5. Outpatient physical therapy, occupational therapy, and speech therapy.

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

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

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

Home Health Care Service Expense Benefits

Covered service expenses and *supplies* for *home health care* are covered when your *physician* indicates you are not able to travel for appointments to a medical office. Coverage is provided for *medically necessary* in-*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.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
4. Intravenous 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*. 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.

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

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

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

Hospice Care Service Expense Benefits

Hospice care benefits are allowable for a *terminally ill member*, with a life expectancy of six months or less, receiving *medically necessary* care under a *hospice care program* or in a home setting. *Respite care* is covered on an *inpatient* or home basis to allow temporary relief to family *members* from the duties of caring for a *covered person* under *hospice* care. Respite days that are applied toward the *member's* cost share obligations are considered benefits provided and shall apply against any maximum benefit limit for these services. *Covered services* and supplies include:

1. Room and board in a *hospice* while the *member* is *inpatient.*
2. Occupational therapy.
3. Speech-language therapy.
4. The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *policy* if the *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.*

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

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

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

1. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
2. 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 *inpatient.*
7. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See your *Schedule of Benefits* for limitations.

Emergency Room Services
In an *emergency* situation (anything that could endanger your life (or your unborn child's life)), you should call 911 or head straight to the nearest *emergency* room. We cover *emergency* medical and *behavioral health* services both in and out of our *service area*. We cover these services 24 hours a day, 7 days a week. Please note some *providers* that treat you within the *emergency* room may not be contracted with us. If that is the case, they may not *balance bill* you for the difference between our *allowed amount* and their billed amount.

Infertility Services
Covered services for *infertility* treatment are limited to diagnostic testing to find the cause of *infertility*, such as diagnostic laparoscopy, endometrial biopsy and semen analysis. Treatment of the underlying medical conditions that cause *infertility* (such as endometriosis, obstructed fallopian tubes and hormone deficiency) are considered a separate benefit. Treatment for *infertility* is limited to a lifetime benefit maximum, per *member*, of three medical ovulation induction cycles.

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

- The full range of contraceptives currently identified by the U.S. Food and Drug Administration (FDA), including: (1) sterilization surgery for women, (2) implantable rods, (3) copper intrauterine devices, (4) intrauterine devices with progestin (all durations and doses), (5) injectable contraceptives, (6) oral contraceptives (combined pill), (7) oral contraceptives (progestin only), (8) oral contraceptives (extended or continuous use), (9) the contraceptive patch, (10) vaginal contraceptive rings, (11) diaphragms, (12) contraceptive sponges, (13) cervical caps, (14) condoms, (15) spermicides, (16) emergency contraception (levonorgestrel) and (17) emergency contraception (ulipristal acetate).
- Coverage is also available for any additional contraceptives approved, granted, or cleared by the FDA (if the patient and the patient's attending provider have determined it to be medically appropriate).

- Contraceptive care, such as: screening, education, provision of contraception, counseling and follow-up care (e.g., management, evaluation and changes, including the removal, continuation and discontinuation of contraceptives).
- Instruction in fertility awareness-based methods, including lactation amenorrhea.

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

Medical and Surgical Expense Benefits

Medical *covered services* and supplies are limited to charges:

1. For *surgery* in a *provider*'s office or at an *outpatient surgical facility,* including services and supplies.
2. For the professional services of a *medical practitioner*, including *surgery;*
3. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
4. For diagnostic testing using radiologic, ultrasonographic, or laboratory services.
5. For chemotherapy and radiation therapy or treatment.
6. For 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 *surgery*. See your *Schedule of Benefits* for benefit levels or additional limits.
10. For reconstructive breast *surgery* charges as a result of a partial or total mastectomy. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas. Reconstructive breast *surgery* following a partial or total mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstructive breast *surgery*. The decision to discharge the *member* following a mastectomy is to be made by the treating *physician* and the *member*. The length of post mastectomy *hospital* stay is based on the unique characteristics, health and medical history of the *member*.
11. For *medically necessary chiropractic care* treatment on an outpatient basis only. *Chiropractic care* services are covered when a participating chiropractor finds that the services are *medically necessary* to treat or diagnose neuromusculoskeletal disorders on an outpatient basis. See your *Schedule of Benefits* for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *policy,* including the *deductible amount* and *cost sharing* provisions.
12. For the diagnosis, evaluation, and treatment of lymphedema, including complex decongestive therapy, and self-management training and education, if the treatment is determined to be *medically necessary* and is provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within the professional's scope of practice.
13. For *medically necessary* procedures involving any bone or joint of the face or head used to treat a condition which prevents normal functioning of the particular bone or joint involved and the condition is caused by congenital deformity, *illness* or bodily *injury*.
    a. Therapeutic procedures include splinting, intraoral prosthetic appliances used to reposition the bones or any other Coverage for *medically necessary* procedures involving any bone or joint of the jaw, face or nonsurgical treatment of temporomandibular joint dysfunction.
    b. Coverage is not provided for orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants, or root canals.
14. For the following types of tissue transplants:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.

    d. Prosthetic tissue replacement, including joint replacements.
    e. Implantable prosthetic lenses, in connection with cataracts.
15. Family Planning for certain professional *provider* contraceptive services and supplies, including but not limited to vasectomy, tubal ligation, and insertion or extraction of prescribed FDA-approved contraceptive devices or drugs along with any associated *medically necessary* examinations.
16. *Medically necessary services* made by a *provider* who render services in an in-*network urgent care center*, including facility costs and supplies.
17. Radiology services, including X-ray, Magnetic Resonance Imaging (MRI), Computed Tomography (CAT scan), Positron Emission Tomography (PET scan), and ultrasound imaging.
18. Allergy testing, injections and serum.
19. *Medically necessary* bariatric *surgery*.
20. *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* are subject to $0 *copay*. *Telehealth services* not provided by *Ambetter Telehealth* would be subject to the same *cost sharing* as the same health care services when delivered to a *member*. 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.
21. For *medically necessary* genetic blood tests.
22. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
23. For *medically necessary* allergy treatment.
24. *Medically necessary* confinement in a *skilled nursing facility*. See your *Schedule of Benefits* for benefit levels or additional limits.
25. For sterilization, including tubal ligation and vasectomies.
26. Coverage for certain services related to the diagnosis, treatment, and correction of any underlying organic cause of *sexual dysfunction*.
27. Congenital cleft lip and palate charges are *medically necessary* care and treatment including, but not limited to, oral and facial *surgery*, surgical management, and *follow-up care* made necessary because of a cleft lip and palate; prosthetic treatment such as obturator, speech appliances and feeding appliances; orthodontic treatment and management; prosthodontic treatment and management; otolaryngology treatment and management; audiological assessment, treatment and management performed by or under the supervision of a licensed doctor of medicine, including surgically implanted amplification devices and physical therapy assessment and treatment. If a *covered member* with a cleft lip and palate is covered by a dental policy, teeth capping, prosthodontics and orthodontics shall be covered by the dental policy to the limit of coverage provided and any excess thereafter shall be provided by this *policy*.
28. Newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.
29. Coverage for *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis.
30. For accidental 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.
31. For respiratory and pulmonary therapy.
32. For the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.
33. For cancer screenings, as follows:
    a. A pelvic examination and pap smear for any nonsymptomatic 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 nonsymptomatic 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 nonsymptomatic *member*, in accordance with the current American Cancer Society guidelines.
34. For *medically necessary* diagnostic and laboratory and x-ray tests.
35. 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.
36. For scalp hair prosthesis expenses for hair *loss* suffered as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia, or permanent *loss* of scalp hair due to *injury*. Such coverage shall be subject to a written recommendation by the treating health care professional stating that the hair prosthesis is a medical necessity.
37. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, or malocclusions.
38. For pulse oximetry screening on a newborn.
39. Well Childcare examinations for children through the age of 12, including child health supervision services, based on American Academy of Pediatric Guidelines. Refer to Preventive Services for a list of well child/well baby services.
40. 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.
41. 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.
42. For testing of pregnant women and other *members* for lead poisoning.
43. For bone mass measurement charges for diagnosis and evaluation of osteoporosis or low bone mass. Bone mass measurement will be covered if at least 23 months have elapsed since the last bone mass measurement was performed, except that we will provide coverage for follow-up bone mass measurement performed more frequently than every 23 months if the follow-up measurement is *medically necessary*. To qualify, one or more of the following criteria must be satisfied:
    a. An individual who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass;
    b. An individual with radiographic osteopenia anywhere in the skeleton;
    c. An individual who is receiving long-term glucocorticoid (steroid) therapy;
    d. An individual with primary hyperparathyroidism;
    e. An individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies;
    f. An individual who has a history of low-trauma fractures; or
    g. An individual with other conditions or on medical therapies known to cause osteoporosis or low bone mass.
44. *Medically necessary* routine foot care, *prior authorization may be required.*

Covered service expenses 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.

Mental health services will be provided on a *network inpatient* and outpatient basis and include mental health conditions. These conditions affect the individual's ability to cope with the requirements of daily

living. If you need mental health and/or *substance use disorder* treatment, you may choose any provider participating in our *behavioral health network*. You can search for *network behavioral health providers* by using our Find a Provider tool at ambetterofnorthcarolina.com or by calling Member Services at 1-833-863-1310 (Relay 711). *Deductible amounts*, *copayment* or *coinsurance* amounts and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

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

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

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

Inpatient

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

Outpatient

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

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

Expenses for these services are covered, if *medically necessary* and may be subject to *prior authorization*. However, we will not require *prior authorization* for withdrawal management services, *inpatient* or

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

In addition, Integrated *Care Management* is available for all of your health care needs, including *behavioral health* and *substance use disorder*. Please call 1-833-863-1310 (Relay 711) to be referred to a care manager for an assessment.

Lymphedema Treatment
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.

North Carolina State Mandated Benefits
The following North Carolina state mandated benefits are covered in the *policy*: Diagnosis and treatment of lymphedema, *emergency* care, minimum *inpatient* stay following delivery of a baby, minimum benefit offerings for alcoholism/drug abuse treatment, access to non-formulary drugs, hearing aids, bone mass measurements, *prescription drug* contraceptives and devices, colorectal cancer screenings, newborn hearing screening, *surveillance tests for ovarian cancer*, mammograms and cervical cancer screening, prostate cancer screenings, reconstructive breast *surgery* following a mastectomy, congenital defects and abnormalities, certain clinical trials, anesthesia and *hospital* charges for certain dental procedures, diabetes, minimum coverage for mental health disorders, certain off-label use for cancer treatment and TMJ joint dysfunction.

Other Dental Services
Anesthesia and *hospital* charges for dental care, for a *member* less than 19 years of age or a *member* who is physically or mentally disabled, are covered if the *member* requires dental treatment to be given in a *hospital* or outpatient ambulatory surgical facility. The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the *member's* condition under general anesthesia. This coverage does not apply to treatment for temporomandibular joint disorders (TMJ).

Coverage is also provided for:

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

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

Outpatient Medical Supplies Expense Benefits

Covered 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 *covered person*. Coverage is limited to diabetes care only.
3. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
4. For the rental of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint *surgery*.
5. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract *surgery*.
6. For one hearing aid per hearing-impaired ear for *covered persons* once every thirty-six (36) months. The coverage shall include all *medically necessary* hearing aids and services that are ordered by a *provider* or an audiologist licensed in North Carolina. Only those persons authorized by law to fit hearing aids, including individuals licensed under Chapter 93D of the General Statutes, are eligible to fit a hearing aid under this provision. Coverage shall be as follows:
    a. Initial hearing aids and replacement hearing aids not more frequently than once every three years.
    b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the *covered person*.
    c. Services, including initial hearing aid evaluation, fitting, and adjustments, and supplies, including ear molds.
7. For the treatment of lymphedema, including equipment, supplies, and gradient compression garments if the treatment is determined to be *medically necessary* and is provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within the professional's scope of practice.
    a. Gradient compression garments:
        i. Require a prescription;
        ii. Are custom-fit for the covered individual; and
        iii. Do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products.
8. Nutritional counseling.
9. Cochlear Implants and Bone Anchored Hearing Aids.

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

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

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

Services not covered:

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

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

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

c. Trifocal;
d. Lenticular; or
e. Contact lenses (in lieu of glasses).

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

Services not covered:
1. Visual therapy;
2. Low vision services and hardware for adults; and
3. *Non-network* care without *prior authorization.*
4. LASIK *surgery*.

Medical Vision Services
*Covered service*s 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* within their *network*, for the purpose of receiving an eye exam for the detection of eye disease. Continued, or *follow-up care* from the eye care *specialist* may require a referral through your *PCP*.

Vision Services under the medical portion of your health plan do not include:
- Referrals to a *specialist* for evaluation and diagnosis of refractive error, including presbyopia, for *members* over the age of 19 years.
- Eye examinations required by an employer or as a condition of employment.
- Radial keratotomy, LASIK and other refractive eye *surgery*.
- Services or materials provided as a result of any workers' compensation law or required by any governmental agency.
- Orthoptics, vision training or subnormal vision aids.

Dental Benefits – Adults 19 years of age or older
Coverage for *dental services* is provided for adults, age 19 and older, for Preventive and Diagnostic, Basic Services and Major Services from a *provider.*
1. Preventive and Diagnostic (Routine *Dental Services*)—Class 1 benefits include:
   a. Routine cleanings;
   b. Oral examinations;
   c. X-rays – bite-wing, full-mouth and panoramic film;
   d. Topical fluoride application.
2. Basic (Basic Dental Care)— Class 2 benefits include:
   a. Minor restorative – metal fillings (posterior teeth) and resin-based filings (limited to anterior teeth);
   b. Endodontics;
   c. Periodontics – scaling, root planning and periodontal maintenance;
   d. Simple extractions;
   e. Prosthodontics – relines, rebase, adjustment and repairs.
3. Major (Major Dental Care)—Class 3 benefits include:
   a. Crowns and bridges;
   b. Dentures;
   c. More complex extractions and surgical services.

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

Services not covered:

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

Prescription Drug Expense Benefits

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

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

1. A *prescription drug.*
2. Prescribed, self-administered anticancer medication.
    a. Such *covered service expenses* shall include those for prescribed, orally administered anticancer medications. The *covered service expenses* shall be no less favorable than for intravenously administered or injected cancer medications that are covered as medical benefits under this *policy*.

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

As used in this section, *Standard Reference Compendia* means (a) The National Comprehensive Cancer Network Drugs & Biologics Compendium; (b) The Thomson Micromedex DrugDex; (c) The Elsevier Gold Standard's Clinical Pharmacology; or (d) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

You cannot refill a prescription until 80 percent of the supply has been used, except under certain circumstances during a state of emergency or disaster.

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

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

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the formulary. For the most current *Ambetter* Formulary or Prescription Drug List or for more information about our pharmacy program, visit ambetterofnorthcarolina.com (under “For Member”, “Pharmacy Resources”) or call Member Services at 1-833-863-1310 (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 must meet all legal requirements.

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

How to Fill a Prescription
Prescription can be filled at an in-*network* retail pharmacy or through our mail-order pharmacy.

If you decide to have your prescription filled at an in-*network* pharmacy, you can use the Provider Directory to find a pharmacy near you. You can access the Provider Directory at AmbetterofNorthCarolina.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 and your *member* identification card.

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

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

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.

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.

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.

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, except as listed on the formulary.
2. For weight loss *prescription drugs* unless otherwise listed on the formulary.
3. For immunization agents, blood, or blood plasma, except when used for preventive care and listed on the formulary.
4. For medication that is to be taken by the *member,* in whole or in part, at the place where it is dispensed.
5. For medication received while the *member* is a patient at an institution, that has a facility for dispensing pharmaceuticals.
6. For a refill dispensed more than 12 months from the date of a *physician's* order.

7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are listed on the formulary.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for *investigational* or *experimental* drugs.
10. For any drug that we identify as therapeutic duplication through the Drug *Utilization Review* program.
11. For more than a 30-day supply when dispensed in any one prescription or refill, or for 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. Please note that only the 90-day supply is subject to the discounted *cost sharing*. Mail orders less than 90 days are subject to the standard *cost sharing* amount.
12. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
13. Foreign Prescription Medications, except those associated with an *emergency* medical condition while you are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this document if obtained in the United States.
14. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventive treatment is related to *member's* vacation during out of country travel. This provision does not prohibit coverage of treatment for aforementioned diseases.
15. For medications used for cosmetic purposes, except for the correction of congenital deformities.
16. For *infertility* drugs, except as otherwise provided in this *policy*.
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 the drugs or dosage amounts have been approved by any governmental regulatory body for that use.
19. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
20. For any drug dispensed from a non-lock-in pharmacy while the *member* is in a lock-in program.
21. For any drug related to *surrogate pregnancy*.
22. For any injectable medication or biological product that is not expected to be self-administered by the *member* at *member's* place of *residence* unless listed on the formulary.
23. Medication refills where a *member* has more than 15 days' supply on hand.
24. For compound drugs unless there is at least one ingredient that requires a prescription.

Certain specialty and non-specialty generic medications may be covered at a higher cost share than other generic products. Please reference the formulary and *Schedule of Benefits* for additional information. For purposes of this section the tier status as indicated by the formulary will be applicable.

Lock-In Program

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

the program via mail. Such communication will include information on duration of participation, pharmacy to which *member* is locked-in, and any *appeals* rights.

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

Prescription Drug Exception Process
Standard exception request
A *member*, a *member's authorized representative* or a *member's* prescribing *provider* may request a standard review of a decision that a drug is not covered by the plan 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 *provider* 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 *provider* may request an expedited review based on exigent circumstances. Exigent circumstances exist when a *member* is suffering from a health condition that may seriously jeopardize the *member*'s life, health, or ability to regain maximum function or when a *member* is undergoing a current course of treatment using a non-formulary drug. Within 24 hours of the request being received, we will provide the *member*, the *member's authorized representative* or the *member's* prescribing *provider* 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 *provider* 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 *provider* 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.

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:

- 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).
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

- 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).
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA.

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

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

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

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

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

Notification
As required by section 2715(d)(4) of the Public Health Service Act, we will provide 60 days advance notice to you before any material modification will become effective, including any changes to preventive benefits covered under this *policy*. You may access our website or the Member Services Department at 1-833-863-1310 (Relay 711) to get the answers to many of your frequently asked questions regarding preventive services. Our website has resources and features that make it easy to get quality care. Our website can be accessed at ambetterofnorthcarolina.com.

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 *member*s 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.

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

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

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

Mammography
Covered service expenses for routine screenings for breast cancer shall include screenings at the following intervals:

1. One or more mammograms a year, as recommended by a *provider*, for a *covered person* who is at risk for breast cancer. The *covered person* is deemed at risk for breast cancer if any one or more of the following are true: (i) the *covered person* has a personal history of breast cancer; (ii) the *covered person* has a personal history of biopsy-proven benign breast disease; (iii) the *covered person's*

mother, sister, or daughter has or has had breast cancer; or (iv) the *covered person* has not given birth prior to the age of thirty (30).
2. One baseline breast cancer screening mammography for a *covered person* between the ages of thirty-five (35) and thirty-nine (39) years.
3. A mammogram every other year for any *covered person* between forty (40) and forty-nine (49) years of age, inclusive or more frequently upon recommendation of a *provider*.
4. A mammogram every year for any *covered person* fifty (50) years of age or older.

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

Other maternity benefits which may require *prior authorization* include:
1. Outpatient and *inpatient* pre- and post-partum care including examinations, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, and childbirth classes.
2. *Physician* home visits and office services.
3. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
4. *Complications of pregnancy*.
5. *Hospital* stays for other *medically necessary* reasons associated with maternity care.
6. For medical services or supplies for maternity deliveries at home, required for medical professional or *medically necessary* treatment.

Note: This provision does not amend the *policy* to restrict any terms, limits, or conditions that may otherwise apply to *covered service expenses* for maternity care. This provision also does not require a *member* who is eligible for coverage under a health benefit plan to:
1. Give birth in a *hospital* or other health care facility; or
2. Remain under *inpatient* care in a *hospital* or other health care facility for any fixed term following the birth of a child.

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

Duty to Cooperate
We do not cover services or supplies related to a *member's pregnancy* when a *member* is acting as a *surrogate* and has entered into a *surrogacy arrangement*. For more information on excluded services, please see the General Non-Covered Services and Exclusions section. *Members* who are a *surrogate* at the time of enrollment or *members* who agree to a *surrogacy arrangement* during the plan year must, within 30 days of enrollment or agreement to participate in a *surrogacy arrangement*, send us written notice of the *surrogacy arrangement* in accordance with the notice requirements to *Ambetter* of North Carolina Inc. at the Member Services Department, 10101 David Taylor Drive, Suite 300, Charlotte, NC 28262. In the event that a *member* fails to comply with this provision, we reserve our right to enforce this EOC provision 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.

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

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

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

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

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)). *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).

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

If requested, the second opinion consultation is to be provided by a *provider* of the *member*'s choice. The *member* may select a *network provider* listed in the Provider Directory. If a *member* chooses a *network provider*, 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 the 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 the *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 local health plan websites. *Members* may receive notifications about available benefits and services through emails from local health plans and through the "My Health Pays" notification system. To inquire about these benefits and services or other benefits available, you may visit our website at www.ambetterofnorthcarolina.com or by contacting Member Services at 1-833-863-1310 (Relay 711).

Transplant Expense Benefits
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 the 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* 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 a lapse in coverage due to non-payment of premium, no services related to transplants will be paid as a *covered service*.

If we determine that *a member* and donor are an appropriate candidate for a *medically necessary* transplant, live donation, *covered service expenses* will be provided for:
1. Pre-transplant evaluation
2. Pre-transplant harvesting of the organ from the donor.
3. Left Ventricular Assist Devices (LVAD)(only when used as a bridge to a heart transplant)
4. Including outpatient *covered services* related to the transplant *surgery*, pre-transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection and other immunosuppressive drug therapy, etc.
5. Pre-transplant stabilization, meaning an *inpatient* stay to *medically stabilize* 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 participating facility.
7. Post-transplant follow-up visits and treatments.
8. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.

9. All costs incurred and medical expenses by the donor; shall be paid under the transplant recipient policy, this excludes travel, lodging, food and mileage. Please refer to the "Member Transplant Travel Reimbursement Policy" for outlined details on reimbursement limitations (https://www.ambetterofnorthcarolina.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 the *residence* to the *Center of Excellence*:
2. We will pay 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 following approved items listed in the *member* transplant reimbursement guidelines. However, you must make the arrangements and provide the necessary paid receipts for reimbursement within six months of the date of service in order to be reimbursed.
    e. Incurred costs related to a certified/registered service animal for the transplant *member* and/or donor.
    f. Please refer to the *member* resources page for *member* reimbursement transplant travel forms and information at ambetterofnorthcarolina.com.

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

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *medically necessary* transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
4. To keep a donor alive for the transplant operation, except when *authorized* through the *Center of Excellence*.
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
6. Related to transplants unauthorized through the *Center of Excellence* and is not included under this provision as a transplant.
7. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("USFDA") regulation, regardless of whether the trial is subject to USFDA oversight.
8. The acquisition cost for the organ or bone marrow, when provided at an un*authorized* facility or not obtained through the *Center of Excellence*.

9. For any transplant services and/or travel related expenses for *member* and donor, when 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 in-*network providers* and services provided at an *urgent care center* including facility costs and supplies. Care that is needed after a *PCP's* normal business hours is also considered to be urgent care. Your zero *cost sharing* preventive care benefits may not be used at an *urgent care center*.

Members are encouraged to contact their *PCP* for an appointment before seeking care from another *provider*, but *network urgent care centers* and walk in clinics can be used when an urgent appointment is

not available. If the *PCP* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-833-863-1310 (Relay 711). The 24/7 Nurse Advice Line is available 24 hours a day, 7 days a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

Wellness and Other Program Benefits
Benefits may be available to *members* for participating in certain programs that we may make available in connection with this *policy*. Such programs may include wellness programs and disease or *care management* programs. These programs may include a reward or an incentive which you may earn by completing different activities.

If you have a medical condition that may prohibit you from participating in these programs, we may require you to provide verification, such as an affirming statement from your *physician*, that your medical condition makes it unreasonably difficult or inadvisable to participate in the wellness or health 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 https://www.ambetterofnorthcarolina.com or by contacting Member Services by telephone at 1-833-863-1310 (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. The programs are optional, and the benefits are made available at no additional cost to the *members*. The programs and benefits available at any given time are made part of this *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 1-833-863-1310 (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 service expenses* under the *policy*. You will be fully responsible for payment for any services that are not *covered service expenses.*
5. Any non-*medically necessary* court ordered care for a medical/surgical or mental health/*substance use disorder* diagnosis, unless required by 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 *provider;* and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness,* or covered under the Preventive Care Expense Benefits provision.

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*.
2. For any portion of the charges that are in excess of the *eligible expense.*
3. For treatment not *medically necessary*.
4. For the reversal of sterilization and the reversal of vasectomies.
5. For abortion, unless necessary to save the life or health of the *member*, or as a result of incest or rape.
6. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Major Medical Expense Benefits provision.
7. For expenses for television, telephone, or expenses for other persons.
8. For telephone consultations between providers, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
9. For stand-by availability of a *medical practitioner* when no treatment is rendered.
10. For *dental service* expenses*,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits.
11. 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.
12. 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. Benefits will be allowed for services that would otherwise be covered under this *policy*.
13. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.

14. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
15. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *policy)*.
16. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*.
17. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *policy*.
18. For hearing aids, except as expressly provided 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. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of ninety (90) consecutive days.
21. Services or supplies for the treatment of occupational *injury* or sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer, or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
22. For fetal reduction *surgery*.
23. Except as specifically identified as a *covered service expense* under the *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.
24. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or Semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any motorized vehicle or conveyance (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).
25. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or *member* of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
26. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
27. For the following "Plan" : acupuncture; naprapathic services; artificial insemination (except where required by federal or state law); 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 section; foot orthotics or corrective shoes; 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*.
28. For diagnostic testing, laboratory procedures screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
29. For court ordered testing or care unless *medically necessary*.

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, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the *surrogate* following childbirth);
    d. Mental Health Services related to the *surrogacy arrangement*;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
    h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement*;
    i. Any complications of the child or *surrogate* resulting from the *pregnancy*;
    j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*; or
    k. Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except where the child is the adoptive child of *member*s 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/or recreational use of cannabis or marijuana.
32. For vehicle installations or modifications which may include, but are not limited to: adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.
33. For all health care services obtained at an urgent care facility that is a *non-network provider*.
34. For expenses, services and treatments from acupuncture *specialists* to stimulate the central nervous system.
35. For immunizations that are not *medically necessary* or medically indicated. This includes those used for travel and occupational.
36. For expenses, services and treatments from a massage therapist to touch and manipulate the muscles and other soft tissues of the body.
37. For expenses, services and treatment from naprapathic *specialists* for conditions caused by contracted, injured, spasmed, bruised and/or otherwise affect myofascial or connective tissue.
38. For expenses, services and treatments from a naturopathic *specialists* for treatment of prevention, self-healing and use of natural therapies.
39. For expense services and treatments related to private duty nursing services provided by a close relative or a *member* in your household when not ordered by a *physician* and not provided by an RN/LPN.
40. For expenses related to dry needling.

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 Health Insurance Marketplace, the date of termination that the Health Insurance Marketplace provides us upon your request of cancellation to the Health Insurance Marketplace;
3. The date we decline to renew this *policy,* as stated in the Discontinuance provision;
4. The date of your death, if this *policy* is an Individual plan;
5. The date a *member's* eligibility for coverage under this *policy* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *policy*;
6. The date a *member's* eligibility for coverage under this *policy* ceases as determined by the Health Insurance Marketplace; or
7. For a covered *eligible child* reaching the limiting age of 26, coverage under this *policy*, will terminate at 11:59 p.m. on the last day of the year in which the *dependent member* turns 26.

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.

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.

Certificate of Creditable Coverage
We will supply a Certificate of Creditable Coverage when you or your *dependent member's* coverage under this *policy* ends or you exhaust continuation of coverage. Keep the Certificate of Creditable Coverage in a safe place. You may request a Certificate of Creditable Coverage from our Member Services Department while you are still covered under this *policy* and up to 24 months following your termination. You may call the Member Services Department at 1-833-863-1310 (Relay 711).

Claims

Notice of Claim
We must receive notice of claim within 30 days of the date the *loss* began or as soon as reasonably possible. *Ambetter* will send a confirmation to the *member* within 15 days after receiving a notice of claim.

Proof of Loss
We must receive written *proof of loss* within 180 days of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than one year late will not be accepted, unless you or your covered *dependent member* had no legal capacity to submit such proof during that year.

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

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

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

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

Ambetter of North Carolina Inc.
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 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 30 days of our initial receipt of the claim and will complete our processing of the claim within 30 days after our receipt of all requested information.

Claim payments that are not made within the specified timeframes shall bear interest at the annual percentage rate of eighteen percent (18percent) beginning on the date following the day on which the claim should have been paid. If additional information was requested by us, interest on claim payments shall begin to accrue on the 31st day after we have received the additional information.

Payment of Claims
Except as set forth in this provision, all benefits are payable to you. Any accrued benefits unpaid at your death, or your *dependent 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*.

Change of Beneficiary
The right to change of beneficiary is reserved to the *member* and the consent of the beneficiary or beneficiaries shall not be required to surrender or assignment of this *policy* or to any change of beneficiary or beneficiaries or to any other changes in this *policy.*

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

Claims incurred outside of the United States for *emergency* care and treatment of a *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 ambetterofnorthcarolina.com.

The amount of reimbursement will be based on the following:

- Member's *policy* and *member* eligibility on date of service;
- Member's responsibility/share of cost based on date of service; and
- 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*'s *policy* at the time of travel. If services are deemed as a true medical *emergency*, *member* will be issued reimbursement payment for any eligible incurred costs, minus *member* cost share obligation.

Assignment

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

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

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

Medicare

This provision describes how we coordinate and pay benefits when a *member* is also enrolled in Medicare and duplication of Coverage occurs. If a *member* is not enrolled in Medicare or receiving benefits, there is no duplication of Coverage and we do not have to coordinate with Medicare.

The benefits under this *policy* are not intended to duplicate any benefits to which *members* are entitled under Medicare.

Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status, and will be adjudicated by us as set forth in this section. In cases where Medicare or another government program has primary responsibility, Medicare benefits will be taken into account for any *member* who is enrolled for Medicare. This will be done before the benefits under this *health plan* are calculated. When Medicare, Part A and Part B or Part C is primary, Medicare's allowable amount is the highest allowable expense.

When a person is eligible for Medicare benefits and Medicare is deemed to be the primary payer under Medicare secondary payer guidelines and regulations, we will reduce our payment by the Medicare primary payment and pay as secondary up to the Medicare allowable amount. However, under no circumstances will this *policy* pay more than it would have paid if it had been the primary plan. Charges for services used to satisfy a *member's* Medicare Part B *deductible* will be applied in the order received by us. Two or more expenses for services received at the same time will be applied starting with the largest first.

This provision will apply to the maximum extent permitted by federal or state law. We will not reduce the benefits due any *member* because of a *member's* eligibility for Medicare where federal law requires that we determine its benefits for that *member* without regard to the benefits available under Medicare.

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

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 service expenses* under that program.

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

Custodial Parent

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

Upon request by the custodial parent, we will:

1. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions, and limitations of the *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 of 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. *Ambetter* shall also have the right 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.

No Third Party Beneficiaries

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

Appeal and Grievance Procedures

Appeal Procedures

Internal Appeal Procedures: When a health insurance plan denies a request of payment for a treatment or service (a claim for plan benefits, you have already received (*post-service claim* denial) or denies your request to authorize treatment or service (*prospective claim* denial), you, or someone you have authorized to speak on your behalf (an *authorized representative*), can request an *appeal* of the plan's decision. If the plan rescinds your coverage or denies your application for coverage, you may also *appeal* the plan's decision. When we receive your *appeal*, we are required to review our decision. When we make an *adverse benefit determination*, we are required to notify you with:

- The reasons for the decision, including the clinical rationale;
- Your right to *appeal* the claim decision;
- Instructions for requesting a written statement of the clinical reviews criteria used;
- Your right to request an *external review*; and
- The availability of assistance from The North Carolina Department of Insurance and the Health Insurance Smart NC program, including the telephone number and address of the program.
- If you do not speak English, you may be entitled to receive *appeals*' information in your native language upon request.
- When you request an *internal appeal*, we must give you our decision as soon as possible, but no later than:
    - 72 hours after receiving your request when you are *appealing* the denial of a claim for urgent care. (If your *appea*l concerns urgent care, you may be able to have the internal *appeal* and external reviews take place at the same time.)
    - 15 days for *appeals* of denials of non-urgent care, you have not yet received (pre-service denials).
    - 30 days for *appeals* of denials of services, you have already received (post-service denials).
    - No extensions of the maximum time limits are permitted unless you consent. The resolution timeframe for standard *appeals* may be extended for up to 14 days if you request the extension or voluntarily agree to extend the *appeal* timeframe. There is no provision for extensions in the case of claims involving urgent care.

Continuing Coverage: We cannot terminate your benefits until all of the *appeals* have been exhausted. However, if our decision is ultimately upheld, you may be responsible for paying any outstanding claims or reimbursing us for claim payments 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.

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

Your rights to file an *appeal* of denial of health benefits: You or your *authorized representative*, such as your health care *provider*, may file the *appeal* for you, in writing, either by mail or by facsimile (fax). For an urgent request, you may also file an *appeal* by telephone.

Ambetter of North Carolina Inc.
Attn: Grievances and Appeals Department
PO Box 10341
Van Nuys, CA 91410
Fax: 1-833-886-7956
Phone 1-833-863-1310 (Relay 711)

You must file the *appeal* within 180 calendar days of the receipt of the notice of claim denial (an *adverse benefit determination*). Failure to file within this time limit may result in us declining to consider the *appeal*. Please include in your written *appeal* or be prepared to tell us the following:

- Name, address and telephone number of the *member*;
- The *member*'s identification number;
- Name of health care provider, address and telephone number;
- Date the health care benefit was provided (if a post-claim denial *appeal*);
- Name, address and telephone number of an *authorized representative* (if *appeal* is filed by a person other than the *member*); and
- A copy of the notice of *adverse benefit determination.*

Non-urgent, pre-service care denial: After you file your *appeal*, we will notify you of all the information that is needed to process the *appeal* within three business days of receipt of the *appeal*. For non-urgent *pre-service denials,* we will notify you of our decision as soon as possible but no later than 15 days of receipt of all the necessary clinical information.

We must make our decision within 48 hours after receipt of the information.

Urgent pre-service care denial: *If* your *claim for benefits is urgent,* you *or* your *authorized representative, or* your *health care provider (provider) may contact* us *with the claim, orally or in writing.*

If the claim for benefits is one *involving urgent care*, we will notify you of our decision as soon as possible, but no later than 72 hours after we receive your claim provided you have given us information sufficient to make a decision.

If you have not given us sufficient information, we will contact you as soon as possible but no more than 24 hours after we receive your claim to let you know the specific information, we will need to make a decision. You must give us the specific information requested as soon as you can but no later than 48 hours after we have asked you for the information.

We will notify you of our decision as soon as possible but no later than 48 hours after we have received the needed information or the end of the 48 hours you had to provide the additional information.

To assure you receive notice of our decision, we will contact you by telephone or facsimile (fax) or by another method meant to provide the decision to you quickly.

In determining whether a claim involves urgent care, we must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a *physician* with knowledge of your medical condition determines that a claim involves urgent care, or an *emergency*, the claim must be treated as an urgent care claim.

Post-service *appeal* (retrospective): If your *appeal* is for a *post-service claim* denial, we will notify you of our decision as soon as possible but no later than 30 calendar days after we have received your *appeal*. If we need more time to make a decision because you have not given us necessary information, you will have 90 calendar days from the date we notify you to give us the information. We will describe the information needed to make our decision in the notice we send you. This is also known as a "retrospective review." We will notify you of our determination as soon as possible but no later than five business days after the benefit determination is made.

We must give you notice that your claim has been denied in whole or in part (paying less than 100 percent of the claim) before the end of the time allotted for the decision.

Rescission of coverage: If we rescind your coverage, you may file an *appeal* according to the following procedures. We cannot terminate your benefits until all of the *appeals* 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.

Your rights to a full and fair review

- We must allow you to review the claim file and to present evidence and testimony as part of the internal claims and *appeals* process.
- We must provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by us (or at our direction) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal *adverse benefit determination* is required to give you a reasonable opportunity to respond prior to that date; and
- Before we can issue a *final internal adverse benefit determination* based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of *final internal adverse benefit determination* is required to be provided to give you a reasonable opportunity to respond prior to that date.
- The *adverse benefit determination* must be written in a manner understood by you, or if applicable, your *authorized representative* and must include all of the following:
    - The titles and qualifying credentials of the person or persons participating in the review process (the reviewers);
    - Information sufficient to identify the claim involved, including the date of service, the health care provider;
    - A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
- As a general matter, we may deny claims at any point in the administrative process on the basis that we do not have *sufficient information*; such a decision; however, will allow you to advance to the next stage of the claims process.

Simultaneous expedited internal review and external review: You, or your *authorized representative*, may request an expedited external review if both the following apply:

1. You have filed a request for an expedited internal review; and
2. After a final *adverse benefit determination*, if either of 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 time frame 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.

Concurrent care decisions

Reduction or termination of ongoing plan of treatment: If we have approved an ongoing plan or course of treatment that will continue over a period of time or a certain number of treatments and we find that the determination was based on a material misrepresentation about your health condition that was knowingly made by you or your *provider* of the service, supply, or other item, we will notify you that we have decided to reduce or terminate the treatment, we will give you notice of that decision allowing sufficient time to *appeal* the determination and to receive a decision from us before any interruption of care occurs.

Request to extend ongoing treatment: If you have received *approval* for an ongoing treatment and wish *to extend the treatment* beyond what has already been approved, we will consider your *appeal* as a request for urgent care. If you request an extension of treatment at least 24 hours before the end of the treatment period, we must notify you soon as possible but no later than 24 hours after receipt of the claim.

An *appeal* of this decision is conducted according to the urgent care *appeals* procedures.

Concurrent urgent care and extension of treatment: Under the concurrent care provisions , any request that involves both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved by us must be decided as soon as possible, taking into account the medical urgencies, and notification must be provided to you within 24 hours after receipt of the claim, provided the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Non-urgent request to extend course of treatment or number of treatments: If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by us does not involve urgent care, the request may be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, e.g., as a *prospective claim* or a *post-service claim*.

If the request is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request must be treated as a claim involving urgent care and decided in accordance with the urgent care claim timeframes, e.g., as soon as possible, taking into account the medical emergencies, but not later than 72 hours after receipt.

Grievance Procedures

Call Member Services
Please contact our Member Services team at 1-833-863-1310 (Relay 711) if you have questions or concerns. We will attempt to answer your questions during initial contact, as most concerns can be resolved with one phone call.

Availability of Grievance Process: There is a *grievance* process which allows a *member* the opportunity to resolve their *grievances*. The process is voluntary and is available for the review of any policy, decision or action that affects a *member*. The *grievance* process does not apply to *grievances* or *appeals* based solely on the basis that the *policy* does not provide or it limits the benefits for the health care service in question, provided the exclusion of the specific service requested is clearly stated in the *policy*.

Filing a Grievance
The *grievance* review is for standard, non-urgent *grievances*. A *grievance* may be submitted in writing by you or your *authorized representative* acting on your behalf. You or your *authorized representative* may file a *grievance* by calling Member Services at 1-833-863-1310 (Relay 711) or in writing by mailing or faxing your *grievance* to:

Ambetter of North Carolina Inc.
Attn: Grievances and Appeals Department
PO Box 10341
Van Nuys, CA 91410
Fax: 1-833-886-7956
Phone 1-833-863-1310 (Relay 711)

Review of Grievance
Within three business days of receiving a *grievance*, we will provide you with the name, address, and telephone number of the person coordinating the review and instructions on submitting written material, including the address to which the material may be submitted. Your attendance is not permitted for the *grievance* review.

The coordinator is an individual other than the person who initially handled the original matter that is the subject of the *grievance*. If the issue is a clinical one, at least one reviewer must be a medical doctor with appropriate expertise to evaluate the matter under consideration.

We will issue a written decision, in clear terms, to you and your *provider*, if applicable, within thirty (30) calendar days after receiving the *grievance*.

The written decision must contain the following information:

- The professional qualifications and licensure of the person or persons reviewing the *grievance*;
- A statement of the reviewers' understanding of the *grievance*;
- The reviewers' decision in clear terms and the contractual or medical rationale in sufficient detail for you to respond further to the reviewers' position;
- A reference to the evidence or documentation used as the basis for the decision;
- A statement that the decision is our final determination in the matter. If the review concerned a *non-certification* and the decision is to uphold the initial *non-certification*, a statement advising you of your right to request an external review once the internal *grievance* process has been exhausted. The North Carolina notice for external review provides the procedures to follow for requesting an external review and should be provided at this time;
- Notice of the availability to contact the North Carolina Commissioner of Insurance for assistance. The notice should include the following information:
  The North Carolina Department of Insurance
  P.O. Box 26387, Raleigh, NC 27611
  1-800-546-5664; and
- A notice of the availability of assistance from the Health Insurance Smart NC, including the telephone number and address of the program. Services provided by the Health Insurance Smart NC are available through the North Carolina Department of Insurance. To reach this program, contact:
  North Carolina Department of Insurance
  Health Insurance Smart NC
  1201 Mail Service Center
  Raleigh, NC 27699-1201
  (855) 408-1212 (Toll Free)
- Note: A North Carolina licensed M.D. will evaluate all *non-certifications*.

For a *grievance* concerning the quality of clinical care delivered by your *provider*, we will acknowledge the *grievance* within ten business days of receipt of the *grievance*. The acknowledgement must advise you that:

1. We will refer the *grievance* to its quality assurance committee for review and consideration or any appropriate action against the *provider*; and
2. State law does not allow for a second-level *grievance* review for *grievances* concerning quality of care.

External Review

North Carolina law provides for review of *non-certification* decisions by an external, *Independent Review Organization* (IRO). An *Independent Review Organization* is an entity that conducts independent external reviews of *appeals* of *non-certifications* and second-level *grievance* review decisions.

The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review. You or someone you have authorized to represent you may request an external review. We will notify you in writing of your right to request an external review each time you:

- Receive a *non-certification* decision; or
- Receive an *appeal* decision upholding a *non-certification* decision.

In order for your request to be eligible for external review, the NCDOI must determine the following:

- That your request is about a medical necessity determination that resulted in a *non-certification* decision;
- That you had coverage with us in effect when the *non-certification* decision was issued;
- That the service for which the *non-certification* was issued appears to be a *covered service* under your *policy*; and
- That you have exhausted our internal review process.

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

Standard External Review

For a standard external review, you will be considered to have exhausted the internal review process if you have:

- Completed our *appeal* and *grievance* review and received a written determination from us; or
- Received notification that we have agreed to waive the requirement to exhaust the internal *appeal* and/or *grievance* process.

If your request for a standard external review is related to a retrospective *non-certification* (a *non-certification* which occurs after you have received the services in question), you will not be eligible to request a standard review until you have completed our internal review process and received a written final determination from us.

If you wish to request a standard external review, you (or your representative) must make this request to NCDOI within 120 calendar days of receiving written notice from us of final determination that the services in question are not approved. When processing your request for external review, the NCDOI will require you to provide the NCDOI with a written, signed authorization for the release of any of your medical records that may need to be reviewed for the purpose of reaching a decision on the external review.

Within ten business days of receipt of your request for a standard external review, the NCDOI will notify you and your *provider* of whether your request is complete and whether it is accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested additional information to the NCDOI within 150 calendar days of the date of our written notice of final determination. If the NCDOI accepts your request, the acceptance notice will include:

- The name and contact information for the Independent Review Organization (IRO) assigned to your

case;
- A copy of the information about your case that we have provided to the NCDOI;
- Notification that we will provide you or your *authorized representative* with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO); and
- Notification that you may submit additional written information and supporting documentation relevant to the initial *non-certification* to the assigned IRO within seven days of the date of the acceptance notice.

Upon NCDOI's request, *we* will, within three business days, provide all information required for the Commissioner to conduct a preliminary review to determine whether:
- You are or were a *covered person* in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a *covered person* in the health benefit plan at the time the health care service was provided.
- The health care service that is the subject of the *non-certification appeal* decision or the second-level *grievance* review decision upholding a *non-certification* reasonably appears to be a *covered service* under the health benefit plan.
- You have exhausted our internal *appeal* and *grievance* processes under G.S. 58-50-61 and G.S. 58-50-62, unless you are considered to have exhausted our internal *appeal* or *grievance* process under G.S. 58-50-79, or unless you have waived your right to conduct an expedited review of the *appeal* decision.
- You have provided all the information and forms required by the Commissioner that are necessary to process an external review.

If you choose to provide any additional information to the IRO, you must also provide that same information to us at the same time using the same means of communication (e.g., you must fax the information to us. if you faxed it to the IRO). When faxing information to us, send it to 1-833-886-7956. If you choose to mail your information, send it to:

Ambetter of North Carolina
Attn: Grievances and Appeals Department
PO Box 10341
Van Nuys, CA 91410

Please note that you may also provide this additional information to the NCDOI within the seven calendar day deadline rather than sending it directly to the IRO and us. The NCDOI will forward this information to the IRO and us within two business days of receiving your additional information.

The IRO shall review all of the information and documents that have been forwarded to the organization by the Commissioner and the insurer. In addition, the assigned review organization, to the extent the documents or information are available, shall consider the following in reaching a decision:
- The *covered person's* medical records.
- The attending health care provider's recommendation.
- Consulting reports from appropriate health care providers and other documents submitted by the insurer, *covered person*, or the *covered person's* treating provider.
- The most appropriate practice guidelines that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy.
- Any applicable clinical review criteria developed and used by the insurer or its designee *utilization review* organization.
- Medical necessity, as defined in G.S. 58-3-200(b) .
- Any documentation supporting the medical necessity and appropriateness of the provider's recommendation.

The IRO will send you written notice of its determination within 45 calendar days of the date the NCDOI received your standard external review request. If the IRO's decision is to reverse the *non-certification*, we will, reverse the *non-certification* decision within three business days of receiving notice of the IRO's decision, and provide coverage for the requested service or supply that was the subject of the *non-certification* decision. If you are no longer covered by us at the time, we receive notice of the IRO's decision to reverse the *non-certification*, we will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been non-certified when first requested.

Expedited External Review
An expedited external review of a *non-certification* decision may be available if you have a medical condition where the time required to complete either an expedited internal *appeal* or a standard external review would reasonably be expected to seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. If you meet this requirement, you may make a written request to the NCDOI for an expedited review after you:

- Receive a *non-certification* decision from us AND file a request with us for an *expedited appeal*; or
- Receive an *appeal* decision upholding the original *non-certification*.

You may also make a request for an expedited external review if you receive an adverse *grievance* review decision concerning a *non-certification* of an admission, availability of care, continued stay or *emergency* care, but have not been discharged from the *inpatient* facility.

In consultation with a medical professional, the NCDOI will review your request and determine whether it qualifies for expedited review. You and your *provider* will be notified within two calendar days if your request is accepted for expedited external review. If your request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard external review if our internal review process was already completed, or (2) require the completion of our internal review process before you may make another request for an external review with the NCDOI. An expedited external review is not available for retrospective *non-certifications*.

Within two calendar days after receiving a request for an expedited external review, the Commissioner shall complete all of the following:

(1) Notify the insurer that made the *non-certification*, *non-certification appeal* decision which is the subject of the request that the request has been received and provide a copy of the request. The Commissioner shall also request any information from the insurer necessary to make the preliminary review set forth in G.S. 58-50-80(b)(2) and require the insurer to deliver the information not later than one day after the request was made.

(2) Determine whether the request is eligible for external review.

(3) If the request is eligible for external review and the *covered person's* treating provider requesting the service that is the subject of the external review has certified the request on a form prescribed by the Commissioner, then one of the following shall apply:

a. For a request made pursuant to subdivision (a)(1) of this section, the request shall be reviewed on an expedited basis because the time frame for completion of an expedited review under G.S. 58-50-61(l) would reasonably be expected to seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function. The Commissioner shall inform the *covered person*, the *covered person's* provider who performed or requested the service, and the insurer whether the Commissioner has accepted the *covered person's* request for an expedited external review. If the Commissioner has accepted the *covered person's* request for an expedited external review, then the Commissioner shall, in

accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame. If the Commissioner has not accepted the *covered person's* request for an expedited external review, then the *covered person* shall be notified.

b. For a request made pursuant to subdivision (a)(2) of this section, the request shall be reviewed on an expedited basis because the time frame for completion of an expedited review under G.S. 58-50-62 would reasonably be expected to seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function. The Commissioner shall inform the *covered person*, the *covered person's* provider who performed or requested the service, and the insurer whether the Commissioner has accepted the *covered person's* request for an expedited external review. If the Commissioner has accepted the *covered person's* request for an expedited external review, then the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame. If the Commissioner has not accepted the *covered person's* request for an expedited external review, then the *covered person* shall be notified.
c. For a request made pursuant to sub-subdivision (a)(3)a. of this section, the request shall be reviewed on an expedited basis because the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function. The Commissioner shall inform the *covered person*, the *covered person's* provider who performed or requested the service, and the insurer whether the review will be conducted using an expedited or standard time frame and shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame.
d. For a request made pursuant to sub subdivision (a)(3)b. of this section, the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the expedited review and inform the *covered person*, the *covered person's* provider who performed or requested the service, and the insurer of its decision.

The IRO will communicate its decision to uphold or reverse the *non-certification* to you within three calendar days or as expeditiously as the *covered person's* medical condition or circumstances require from the date the NCDOI received your request for an expedited external review. If the IRO's decision is to reverse the *non-certification*, we will, within one day of receiving notice of the IRO's decision, reverse the *non-certification* decision for the requested service or supply that is the subject of the *non-certification* decision. If you are no longer covered by us at the time, we receive notice of the IRO's decision to reverse the *non-certification*, we will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been non-certified when first requested.

The IRO's external review decision is binding on us and you, except to the extent you may have other remedies available under applicable federal or state law. You may not file a subsequent request for an external review involving the same *non-certification* decision for which you have already received an external review decision.

For further information about external review or to request an external review, contact the NCDOI at:

By Mail: NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
(Fax) 919-807-6865

In Person: NC Department of Insurance
Albemarle Building
325 N. Salisbury St.
Raleigh, NC
Toll-free telephone number 855-408-1212
www.ncdoi.com/smart

The Health Insurance Smart NC Program is also available to provide assistance to consumers who wish to file an *appeal* or *grievance* with their health plan.

Department of Insurance Complaints
The North Carolina Department of Insurance is available to assist insurance consumers with insurance related problems and questions. You may inquire in writing to the Department at PO Box 26387, Raleigh, NC, 27611 or by telephone at 1-800-546-5664.

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard Grievance	180 Calendar Days	3 Business Days	30 Calendar Days	N/A
Standard Pre-Service Appeal	180 Calendar Days	3 Business Days	15 Calendar Days	14 Calendar Days
Expedited Pre-Service Appeal	180 Calendar Days	N/A	72 Hours	N/A
Standard Post-Service Appeal	180 Calendar Days	3 Business Days	30 Calendar days	N/A
External Review	120 Calendar Days	N/A	45 Calendar Days	N/A
Expedited External Review	120 Calendar Days	N/A	72 Hours	N/A

General Provisions

Entire Policy
This *policy,* with the enrollment application*, 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.

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 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.

You will be provided 30 days' notice of a *rescission*.

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

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

We protect all oral, written and electronic PHI. We follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. We are required to notify you about these practices every year. This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. If you need more information or would like the complete notice, please visit https://www.ambetterofnorthcarolina.com/privacy-practices.html or call Member Services at 1-833-863-1310 (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://www.ambetterofnorthcarolina.com/language-assistance.html.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de North Carolina, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-863-1310 (Relay 711).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter of North Carolina 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 1-833-863-1310 (Relay 711).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter of North Carolina, 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 1-833-863-1310 (Relay 711).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter of North Carolina 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-833-863-1310 (Relay 711). 로 전화하십시오.
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter of North Carolina, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-833-863-1310 (Relay 711).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter of North Carolina ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل 1-833-863-1310 (Relay 711).
Hmong:	Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Ambetter of North Carolina, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-833-863-1310 (Relay 711).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter of North Carolina вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-833-863-1310 (Relay 711).
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter of North Carolina, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-833-863-1310 (Relay 711).
Gujarati:	જો તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter of North Carolina વિશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-833-863-1310 (Relay 711) ઉપર કૉલ કરો.
Mon-Khmer, Cambodian:	ប្រសិនលោកអ្នកឬ នរណាម្នាក់ដែលអ្នកកំពុងជួយមានសំណួរអំពី Ambetter of North Carolina អ្នកមានសិទ្ធិទទួលបានជំនួយនិងព័ត៌មានជាភាសារបស់លោកអ្នកដោយឥតគិតថ្លៃ។ សូមនិយាយទៅកាន់អ្នកបកប្រែភាសាលេខ 1-833-863-1310 (Relay 711).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from North Carolina 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 1-833-863-1310 (Relay 711) an.
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter of North Carolina के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-833-863-1310 (Relay 711).पर कॉल करें।
Laotian:	ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ Ambetter of North Carolina, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ ໃຫ້ໂທຫາ 1-833-863-1310 (Relay 711).
Japanese:	Ambetter of North Carolina 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、1-833-863-1310 (Relay 711). までお電話ください。

AMB18-NC-C-00069

Statement of Non-Discrimination

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

Ambetter of North Carolina Inc.:

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

If you need these services, contact *Ambetter* of North Carolina Inc. at 1-833-863-1310 (Relay 711).
If you believe that *Ambetter* of North Carolina Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a *grievance* with: *Ambetter* of North Carolina Inc., ATTN: *Ambetter* Grievances and Appeals Department, PO Box 10341 Van Nuys, CA 91410, 1-833-863-1310 (Relay 711), Fax 1-833-886-7956. You can file a *grievance* by mail or fax. If you need help filing a *grievance*, *Ambetter* of North Carolina Inc. is available to help you. You can also file a civil rights *complaint* with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TTY).

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