ambetter. FROM home state health

2023 Evidence of Coverage

Ambetter + Adult Vision + Adult Dental

Ambetter.HomeStateHealth.com

99723MO011-2023A

Ambetter from Home State Health
Individual EPO Health Benefit Plan
Issued and Underwritten by Celtic Insurance Company

Home Office: 7711 Carondelet Ave., St. Louis, MO, 63105

Individual Member Contract

In this *contract,* "you" or "your" will refer to the subscriber and/or any *dependents* enrolled in this *contract* and "we," "our," or "us" will refer to Home State Health.

TEN DAY RIGHT TO RETURN CONTRACT

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

AGREEMENT AND CONSIDERATION

We issued this *contract* and the corresponding *schedule of benefits* in consideration of the enrollment application and the payment of the first premium. We will provide benefits to you, the *member*, for covered *losses* due to *illness* or bodily *injury* as outlined in this *contract.* Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

This *contract*, including the endorsements and the attached papers, if any, constitutes the entire *contract* of insurance. No change in this *contract* shall be valid until approved by an executive officer of the insurer and unless such *approval* be endorsed hereon or attached hereto. No agent has authority to change this *contract* or to waive any of its provisions.

GUARANTEED RENEWABLE

Annually, we must file this product, the cost share and the rates associated with it for *approval*. Guaranteed renewable means that your plan will be renewed into the subsequent year's approved product on the anniversary date unless terminated earlier in accordance with *contract* terms. You may keep this *contract* (or the new *contract* you are mapped to for the following year) in force by timely payment of the required premiums. In most cases you will be moved to a new *contract* each year, however, we may decide not to renew the *contract* as of the renewal date if: (1) we decide not to renew all *contracts* issued on this form, with a new *contract* at the same metal level with a similar type and level of benefits, to residents of the state where you then live; (2) we withdraw from the *service area*; or (3) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *covered services*.

In addition to the above, this guarantee for continuity of coverage shall not prevent us from cancelling or non-renewing this *contract* in the following events: (1) non-payment of premium; (2) a *member* is found to be in material breach of this *contract*; or (3) 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 will change the rate table used for this *contract* form. Each premium will be based on the rate table in effect on that premium's due date. The *contract* plan, and age of *members,* type and level of benefits, and place of *residence* on the premium due date are some of the factors used in determining your premium rates. We have the right to change premiums however, all premium rates charged will be

guaranteed for a calendar year.

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

This health benefit plan requires that all health care services be delivered by a *network provider*. Services rendered by a *non-network provider* are not covered under this plan, except for emergency services and two (2) sessions per year to a licensed psychiatrist, licensed psychologist, licensed professional counselor or a licensed clinical worker for the purpose of diagnosis or assessment of mental health.

As a cost containment feature, this *contract* contains *prior authorization* requirements. Benefits may be reduced or not covered if the requirements are not met. Please refer to the *Schedule of Benefits* and the Prior Authorization section.

WARNING: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

IMPORTANT INFORMATION

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

The coverage represented by this *contract* is under the jurisdiction of the Missouri Department of Commerce and Insurance

*This contract does not include pediatric dental services. Pediatric dental coverage is included in some health plans, but can also be purchased as a standalone product. Please contact y*our *insurance carrier or producer, or seek assistance through healthcare.gov, if you wish to purchase pediatric dental coverage or a stand-alone dental services product.*

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

Celtic Insurance Company

Kevin J. Counihan, President

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INTRODUCTION

Welcome to Ambetter from Home State Health ("Ambetter")! This *contract* is issued and underwritten by Celtic Insurance Company, and network access and administrative services are provided by Home State Health.

We have prepared this *contract* to help explain your coverage. Please refer to this *contract* whenever you require medical services. It describes:

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

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

Because many of the provisions of this *contract* are interrelated, you should read this entire *contract* to gain a full understanding of your coverage. Many words used in this *contract* have special meanings when used in a healthcare setting – these words are *italicized* and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. This *contract* also contains exclusions, so please be sure to read this entire *contract* carefully.

How to Contact Us
Ambetter from Home State Health
7711 Carondelet Ave.
St. Louis, MO, 63105

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. CST
Member Services 1-855-650-3789
TTY 711
Emergency 911
24/7 Nurse Advice Line 1-855-650-3789

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

Our interpreter services are provided at no cost to you. We have 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 oral interpretation, or to request materials in Braille or large font.

To arrange for interpreter services, please call Member Services at 1-855-650-3789, or for the hard of hearing TTY 711.

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, call Member Services at 1-855-650-3789 (TTY 711).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

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

You have the right to:

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

primary care physician assignment, providers, advance directive information, referrals and *authorizations*, benefit denials, *member* rights and responsibilities, and our other rules and guidelines. We will notify you at least 31 days before the *effective date* of the modifications. Such notices shall include the following:

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 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 *medical practitioner*(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 *primary care physician* within the *network*. You also have the right to change your *primary care physician* or request information on *network providers* close to your home or work.
18. Know the name and job title of people giving you care. You also have the right to know which *physician* is your *primary care physician*.
19. An interpreter when you do not speak or understand the language of the area.
20. A second opinion by a *network 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. Advance directives are forms you can complete to protect your rights for medical care. It can help your *primary care physician* and other providers understand your wishes about your health. Advance directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself. *Members* also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive. Examples of advance directives include:

    a. Living Will
    b. Health Care Power of Attorney
    c. "Do Not Resuscitate" Orders.

You have the responsibility to:

1. Read the entire *contract.*
2. Treat all *physicians* and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about your health that we or your *medical practitioners* need in order to provide care. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your *physician* until you understand the care you are receiving.

4. Review and understand the information you receive about us. You need to know the proper use of *covered services*.
5. Show your member identification card and keep scheduled appointments with your *physician*, and call the *physician's* office during office hours whenever possible if you have a delay or cancellation.
6. Know the name of your assigned *primary care physician*. You should establish a relationship with your *physician*. You may change your *primary care physician* verbally or in writing by contacting 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. Understand your health problems and participate, along with your *health care professionals* in developing mutually agreed upon *treatment* goals to the degree possible.
9. Follow the *treatment* plans and instructions for care that you have agreed on with your *physicians*.
10. Tell your *physician* if you do not understand your *treatment* plan or what is expected of you. You should work with your *physician* to develop *treatment* goals. If you do not follow the *treatment* plan, you have the right to be advised of the likely results of your decision.
11. Follow all health benefit plan guidelines, provisions, policies and procedures.
12. Use any emergency room only when you think you have a medical *emergency*. For all other care, you should call your *primary care physician*.
13. Provide all information about any other medical coverage you have upon enrollment in this plan. If, at any time, you get other medical coverage besides this coverage, you must tell the entity with which you enrolled.
14. Pay your monthly premiums, *deductible amount, copayment amounts*, and *coinsurance amounts* on time.
15. Notify us, or the entity you enrolled with, of any enrollment related changes that would affect your *contract* within 60 days of the event. Enrollment related changes include the following: birth of a child, adoption, marriage, divorce, change of address, adding/removing a dependent, *spouse*/domestic partner becomes eligible under a different insurer, or incarceration where member cost share would need to transfer from one *contract* to another *contract*.

IMPORTANT INFORMATION

Provider Directory

A listing of *network providers* is available online at http://ambetter.homestatehealth.com/findadoc. We have *network physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide you with your health care services. You may find any of our *network providers* by completing the "Find a Provider" function. There you will have the ability to narrow your search by provider specialty, zip code, gender, whether or not they are currently accepting new patients, and languages spoken. Your search will produce a list of providers based on your search criteria and will give you other information such as name, address, phone number, office hours, specialty, and board certifications.

At any time, you can request a copy of the provider directory at no charge by calling Member Services at 1-855-650-3789. We can help you pick a *primary care physician*. We can make your choice of *primary care physician* effective on the next business day.

Call the *primary care physician*'s office if you want to make an appointment. If you need help, call Member Services at 1-855-650-3789. We will help you make the appointment.

Member Identification Card

We will mail you a member identification card after we receive your completed enrollment materials and you have paid your initial premium payment. This card is proof that you are enrolled in an Ambetter plan. You need to keep this card with you at all times. Please show this card every time you go for any service under this *contract.* The member identification card will show your name, member identification number, the phone numbers for Member Services, pharmacy, and 24/7 Nurse Advice Line, and *copayment amounts* required at the time of service. If you do not get your member identification card within a few weeks after you enroll, please call Member Services at 1-855-650-3789. We will send you another card. A temporary member identification card can be downloaded from our secure member portal at http://ambetter.homestatehealth.com/.

Website

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

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

Quality Improvement

We are committed to providing quality health care for you and your family. Our primary goal is to improve your health and help you with any *illness* or disability. Our program is consistent with National Committee on Quality Assurance (NCQA) standards. 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 *network*.
2. Providing programs and educational items about general health care and specific diseases.
3. Sending reminders to *members* to get annual tests such as a physical examination, preventive health screenings, and immunizations.
4. A Quality Improvement Committee that includes *network providers* to help us develop and monitor our program activities.
5. Investigating any *member* concerns regarding care received.

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

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

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.

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

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

Please review the Access to Care and Medical Expense Benefits sections of this *contract* for detailed information.

DEFINITIONS

In this *contract*, italicized words are defined. Words not italicized will be given their ordinary meaning. Wherever used in this *contract*:

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

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

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

Adverse determination means a decision by us which results in: a determination by a health carrier or a utilization review entity that an admission, availability of care, continued stay or other health care service furnished or proposed to be furnished to an enrollee has been reviewed and, based upon the information provided, does not meet the utilization review entity or health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or are experimental or investigational, and the payment for the requested service is therefore denied, reduced or terminated. Refer to the Complaint and Appeal Process section of this *contract* for information on your right to *appeal* an *adverse benefit determination*.

Alcohol Treatment Facility means a residential or nonresidential *facility* certified by the Missouri Department of Mental Health for *treatment* of alcohol abuse.

Allowed amount (also see ***eligible service expense***) is the maximum amount we will pay a provider for a *covered service*. When a *covered service* is received from a *network provider*, the *allowed amount* is the amount the provider agreed to accept from us as payment for that particular service. In all cases, the *allowed amount* will be subject to *cost sharing* (e.g., deductible, *coinsurance* and *copayment*) per the *member's* benefits. This amount excludes 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 non-network care that is otherwise covered under your plan and that is provided by a *non-network provider* at a *network facility*, unless you gave informed consent before receiving the services. You also will not be responsible for *balance billing* by a *non-network provider* or *non-network facility* for emergency services

or air ambulance services. See *Balance Billing* and Non-Network Provider definitions for additional information. If you are balance billed in these situations, please contact Member Services immediately at the number listed on the back of your member identification card.

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

Appeal means a written *complaint regarding:*

1. Claims payment, handling or reimbursement for health care services or
2. A *complaint* regarding an *adverse determination* made pursuant to *utilization review*.

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

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

Autism spectrum disorder means a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. It is a 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.

Authorization or ***authorized*** means our decision to approve the *medical necessity* or the appropriateness of care for an enrollee.

Authorized representative means an individual who represents a *member* who is any of the following:

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

Autism spectrum disorder means a neurological and developmental disorder that begins early in childhood and lasts throughout a person's life. It is a condition related to brain development that impacts how a person perceives and socializes with others, causing problems in social interaction and communication. It may include intellectual impairment but not always. The disorder may include problems with the ability to recognize or share interests or emotional experiences, problems expressing

or understanding verbal or non-verbal communication, and/or developing or maintaining relationships. Repetitive patterns of behavior or an inability to tolerate change is often seen.

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

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

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

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

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

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

Care management means a program in which a registered nurse, known as a care manager, assists a *member* through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and health care benefits available to a *member*. *Care management* when mutually agreed to by us, the *member* and the *member's physician*.

Center of Excellence means a *hospital* that:

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

Claimant is the *member* or *member's authorized representative* who has contacted the plan to file a *complaint* or *appeal* or who has contacted the Missouri Department of Commerce and Insurance to file an external review.

Coinsurance amount means the percentage of *covered services* that you are required to pay when you receive a *covered service*. C*oinsurance* 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 but is not limited to: ectopic pregnancy, spontaneous abortion, eclampsia, missed abortion, and similar medical surgical conditions of comparable severity.
2. An emergency cesarean section or a non-elective cesarean section.

Concurrent review means *utilization review* conducted during a patient's *hospital* stay or course of treatment.

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

Contract when *italicized,* refers to this *contract as* issued and delivered to you. It includes the attached pages, the enrollment applications, the *Schedule of Benefits*, and any amendments or riders.

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

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

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

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

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

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

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

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

1. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
2. Preparation and administration of special diets;

3. Supervision of the administration of medication by a caregiver;
4. Supervision of self-administration of medication; or
5. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, educational care or recreational care.

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

If you are a covered *member* in a family of two or more *members*, you will satisfy your *deductible amount* when:
1. You satisfy your individual *deductible amount*; or
2. Your family satisfies the family *deductible amount* for the *calendar year.*

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

The *deductible amount* does not include any *copayment amounts.*

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 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 applicable date a *member* becomes covered under this *contract* for *covered services*.

Eligible child means the child of a primary *subscriber*, if that child is less than 26 years of age. As used in this definition, "child" means:
1. A natural child;
2. A legally adopted child;
3. A foster child placed in your custody;
4. A child placed with you for adoption;
5. A child for whom legal guardianship has been awarded to you, your *spouse,* or domestic partner.; or
6. A stepchild.

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

Eligible service expense means a *covered service* as determined below.
1. For *network providers:* When a *covered service* is received from a *network provider*, the *eligible service expense* is the contracted fee with that provider.
2. For non-*network providers*, unless otherwise required by Federal or Missouri law, the *eligible service expense* is as follows:
    a. When a *covered service* is received from a *non-network provider* within a *network facility* as a result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that has

been mutually agreed upon by us and the provider as payment in full. However, if the provider has not agreed to accept a negotiated fee with us as payment in full, the *eligible service expense* is a reasonable reimbursement based upon the health care professional provider's services. You should not be billed for the difference between the amount we pay and the provider's charge but you will be subject to *cost sharing* based upon the reimbursement amount. 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 facility* or from a *non-network provider* at a *non-network facility* as a result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full. However, if the provider has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by federal or Missouri law, the *eligible service expense* is a reasonable reimbursement as determined by us. *Member cost share* will be calculated from the recognized amount based upon *applicable law.* You should not be billed for the difference between the amount we pay and the provider's charge but you will be subject to *cost sharing* based upon the qualifying payment amount. 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* within a *network* hospital or a *network* ambulatory surgical center not as a result of an *emergency*, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full. However, if the provider has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by federal or Missouri law, the *eligible service expense* is a reasonable reimbursement as determined by us. Unless you receive and sign the necessary written notice and consent document under federal law before the services are provided, you should not be billed for the difference between the amount we pay and the provider's charge but you will be subject to *cost sharing* based upon the qualifying payment amount. *Member cost share* will be calculated from the recognized amount based upon *applicable law.* If you are balance billed in these situations, please contact Member Services immediately at the number listed on the back of your member identification card.

d. When a covered air ambulance service is received from a non -network provider, the eligible service expense is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full. If the provider has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by *applicable law*, the eligible service expense is reimbursement as determined by us and as required by *applicable law*. Member cost share will be calculated from the recognized amount based upon *applicable law*. You should not be balance billed for the difference between the amount we pay and the provider's charges, but you may be subject to cost sharing obligations. If you are balance billed in these situations, please contact Member Services immediately at the number listed on the back of your member identification card. For all other *covered services* received from a *non-network provider* for which any needed *authorization* is received from us, the *eligible service expense* is the lesser of: (1) the negotiated fee, if any, that has been mutually agreed upon by us and the provider; or (2) the greatest of the following: (i) the amount that would be paid under Medicare; (ii) the amount for the *covered service* calculated using the same method we generally use to determine payments for *non-network providers*; or (iii) the contracted amount paid to *network providers* for the *covered service* (if there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts). In addition to applicable *cost sharing*, you may be balance billed for these

services.

Emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate *medical care* is required, which may include, but shall not be limited to:

(a) Placing the person's health in significant jeopardy;
(b) Serious impairment to a bodily function;
(c) Serious dysfunction of any bodily organ or part;
(d) Inadequately controlled pain; or
(e) With respect to a pregnant woman who is having contractions:
    a. That there is inadequate time to effect a safe transfer to another *hospital* before delivery; or
    b. That transfer to another *hospital* may pose a threat to the health or safety of the woman or unborn child

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

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

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. Administration (FDA) regulation, regardless of whether the trial is subject to FDA oversight;
2. An *unproven service;*
3. Subject to FDA *approval*, and:
    a. It does not have FDA *approval*;
    b. It has FDA *approval* only under its Treatment Investigational New Drug regulation or a similar regulation;
    c. It has FDA *approval*, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a FDA-approved drug is a use that is determined by us to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
        iii. Not an *unproven service*.
    d. It has FDA *approval*, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the FDA or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*
4. Experimental or investigational according to the provider's research protocols.

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

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

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

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

Facility means any medical or *behavioral health* services organization that allows individuals to be treated on an inpatient or outpatient basis. This includes but is not limited to *extended care facilities, alcoholism treatment facilities, surgical facilities, habilitation and rehabilitation facilities,* and *hospitals*.

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

If no credible scientific evidence is available, then standards that are based on *physician* specialty society recommendations or professional standards of care may be considered. We reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered service* under the *contract*. The decision to apply *physician* specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by us.

Grievance means a written *complaint* submitted by or on behalf of an enrollee regarding the:

1) Availability, delivery or quality of health care services, including a *complaint* regarding an *adverse determination* made pursuant to *utilization review*;
2) Claims payment, handling or reimbursement for health care services; or
3) Matters pertaining to the contractual relationship between an enrollee and a health carrier.

Habilitation or ***habilitation services*** 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 care professional means a licensed medical practitioner, physician, psychologist, nurse practitioner, *behavioral health* practitioner, or other health care practitioner licensed, accredited, or certified to perform health care services consistent with state law. A *health care professional* 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.

Hearing loss, also referred to as loss or impairment of speech or hearing, includes those communicative disorders generally treated by a speech pathologist, audiologist or speech/language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both, and which fall within the scope of his or her license or certification.

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

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

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

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

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

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

Hospital means an institution that:

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

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

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

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

Independent review organization (IRO) means an entity that is accredited by a nationally recognized private accrediting organization to conduct independent external reviews of *adverse benefit determinations* and by the Missouri Department of Commerce and Insurance in accordance with Missouri law.

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

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

Intensive care unit means that part of a *hospital* service specifically designed as an *intensive care unit* permanently equipped and staffed to provide more extensive care for critically ill or injured patients than available in other *hospital* rooms or wards, the care to include close observation by trained and qualified personnel whose duties are primarily confined to the part of the *hospital* for which an additional charge is made.

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

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

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

Maximum out-of-pocket amount means the sum of the *deductible amount*, *prescription drug deductible amount* (if applicable), *copayment amount* and *coinsurance amount* of *covered services*, as shown in the *schedule of benefits*.

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

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

Medically necessary means, based on our determination, any medical service, items, supply or *treatment* to diagnose and treat a *member's illness or injury*:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to *generally accepted standards of medical practice*;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;

5. Is not *experimental or investigational*;
6. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; and
7. When specifically applied to a *hospital* confinement, it means that the diagnosis and treatment of your medical symptoms or conditions cannot be safely provided as an *outpatient*.

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

Medically stabilized for non-emergency services means that the person is no longer experiencing further deterioration as a result of a prior *injury* or *illness* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care, nor is any material deterioration of the condition likely to occur before an individual may be transferred. Acute *medical care* does not include *acute rehabilitation*. Stabilize, with respect to an *emergency medical condition*, means to provide medical treatment of the condition as necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer to a network *facility* or discharge of the individual from a *facility.* (See Ambulance Service Benefits provision under the Medical Expense Benefits section).

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

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

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

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

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

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

Network eligible service expense means the *eligible service expense* for services or supplies that are provided by a *network provider*. For *facility* services, this is the *eligible service expense* that is provided at

and billed by a *network facility* for the services of either a *network* or non-*network provider*. *Network eligible service expense* includes benefits for *emergency* health services even if provided by a non-*network provider*.

Network provider means any licensed person or entity that has entered into a *contract* with Ambetter from Home State Health to provide *covered services* to members enrolled under this *contract* including but not limited to, hospitals, specialty hospitals, urgent care facilities, physicians, pharmacies, laboratories and other health professionals within our *service area*.

Non-elective cesarean section *means:*

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

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

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

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

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

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

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

Outpatient contraceptive services means consultations, examinations, and medical services, provided on an *outpatient* basis and related to the use of contraceptive methods, to prevent *pregnancy,* which has been approved by the United States Food and Drug Administration (FDA).

Outpatient surgical facility means any *facility* with a medical staff of *physicians* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This includes ambulatory surgical centers. This does not include facilities such

as: acute-care clinics, *urgent care centers*, ambulatory-care clinics, free-standing *emergency* facilities, and *physician* offices.

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

Post-service claim means any claim for a benefit under this *contract* that has already been provided.

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

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

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

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

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

Primary care physician (PCP) means a *physician* 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 the Plan. 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 certification made pursuant to a *prior authorization* review, or notice as required by a health carrier or utilization review entity prior to the provision of health care services.

Prior authorization review means a *utilization review* conducted prior to an admission or a course of treatment, including but not limited to pre-admission review, pre*treatment* review, *utilization review*, and case management

Proof of loss means information required by us to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, medical bills or records, other plan information, 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*, *extended care facility,* or other healthcare facility.

Qualified health plan or ***QHP*** means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each 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 (QHP)* in the individual market.

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

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 type of care must be *acute rehabilitation*, sub-acute rehabilitation, or *intensive day rehabilitation*, and it includes *rehabilitation* therapy, cardiac *rehabilitation* therapy, and pain management programs. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive rehabilitation therapy or treatment under a pain management program.

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

1. Is licensed by the state as a *rehabilitation facility*; and
2. Operates primarily to provide 24-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 medical practitioner means a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation 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.

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.

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

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

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

Retrospective review means *utilization review* of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

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

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

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

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

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

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

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

Spouse means the person to whom you are lawfully married.

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

Substance use disorder means a disorder that affects a person's brain and behavior, leading to an inability to control his/her use of substances (e.g., alcohol, medications and legal or illegal drugs). Symptoms can range from moderate to severe, with addiction being the most severe form of a substance use disorder. Substance use disorder benefits are defined as benefits for items or services for substance use disorder conditions listed in ICD 10 Chapter 5 (F), except for subchapter 1 (F01-09) and subchapter 8 (F70-79).

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

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

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 has a fertilized egg placed in her body but the egg is not her own.

Telehealth services means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, *care management*, and self-management of a patient's health care while the patient is at the originating site and the provider for telehealth is at a distant site. *Telehealth services* includes synchronous interactions and asynchronous store and forward transfers.

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

Terminally ill means a *physician* has given a prognosis that a *member* has 12 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 *member* or an insured *dependent member* except in those jurisdictions where statutes or common law does not specifically prohibit our right to recover from these sources.

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

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

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

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

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

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

Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, *prior authorization* review, second opinion, certification, concurrent review, *care management*, discharge planning or *retrospective review*. *Utilization review* shall not include elective requests for clarification of coverage.

Utilization review entity refers to Ambetter, as this is the entity that will perform *prior authorization* reviews for requested services.

DEPENDENT MEMBER COVERAGE

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

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

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

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

The coverage for newly born children shall consist of coverage of injury or *illness* including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth. If notice of the newborn is given to us by the Health Insurance Marketplace within the 31 days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 days after the birth of the child. If notice is given by the Health Insurance Marketplace within 60 days of the birth of the child, we may not deny coverage of the child due to failure to notify us of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st day after its birth, unless we have received notice from the entity that you have enrolled (either the Health Insurance Marketplace or us). If you have requested enrollment application materials from us, we will allow up to ten additional days of coverage after the original 31 days of coverage in order for you to complete the forms and submit them to us.

Coverage for an Adopted Child
An *eligible child* legally placed for adoption with a *member* will be covered from the date of birth if a petition for adoption is filed within 31 days of the birth of such child, or 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 on the same basis as any other dependent. Coverage shall include the necessary care and treatment of medical 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 date that you or your *spouse* assume physical custody of the child for the purpose of adoption pursuant to an adoption proceeding.

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

ONGOING ELIGIBILITY

For All Members

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

1. The date of a *member's* death;
2. The primary *member* residing outside the *service area* or moving permanently outside the *service area* of this *contract*;
3. The date that a *member* is no longer within the Grace Period based on a failure to make timely payment. See the Grace Period provision for additional details;
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 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 *contract*, or any later date stated in your request.

If you have material modifications (examples include a change in life event (marriage, death) or family status), or questions related to your health insurance coverage, contact the Health Insurance Marketplace at www.healthcare.gov or 1-800-318-2596. If you enrolled through Ambetter contact Member Services Department: 855-650-3789 TTY 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*, coverage will terminate the 31st day of December the year that the dependent turns 26 years of age.

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

1. Incapable of self-sustaining employment due to mental or physical disability that began before the age limit was reached; and
2. Mainly *dependent* on the primary *member* for support.

Open Enrollment

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

Special Enrollment Period

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

1. A *qualified individual* or *dependent loses minimum essential coverage*, non-calendar year group or individual health insurance coverage, *pregnancy*-related coverage, access to health care services through coverage provided to a pregnant enrollee's unborn child, or medically needed coverage;
2. A *qualified individual* gains a *dependent* or becomes a *dependent* through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order. In the case of marriage, at least one *spouse* must demonstrate having minimum essential coverage as described in 26 CFR 1.5000A-1(b) for one or more days during the 60 days preceding the date of marriage;

3. A *qualified individual* or *dependent*, who was not previously a citizen, national, or lawfully present individual gains such status; or who is no longer incarcerated or whose incarceration is pending the disposition of charges;
4. A *qualified individual's* enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or its instrumentalities as evaluated and are determined by the Health Insurance Marketplace;
5. An enrollee or *dependent* adequately demonstrates to the Health Insurance Marketplace that the plan in which he or she is enrolled substantially violated a material provision of its *contract* in relation to the enrollee;
6. A *qualified individual*, enrollee, or *dependent*, adequately demonstrates to the Health Insurance Marketplace that a material error related to plan benefits, *service area*, or premium influenced the qualified individual's or enrollee's decision to purchase the QHP;
7. An enrollee or *dependent* enrolled in the same plan is determined newly eligible or newly ineligible for *advance premium tax credits* or has a change in *eligibility* for *cost sharing reductions*;
8. A *qualified individual* or *dependent* who is enrolled in an eligible employer-sponsored plan is determined newly eligible for *advance premium tax credits* based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-2I(3);
9. A *qualified individual*, enrollee, or *dependent* gains access to new QHPs as a result of a permanent move, and had minimum essential coverage as described in 26 CFR 1.5000A–1(b) for one or more days during the 60 days preceding the date of the permanent move;
10. A *qualified individual* or *dependent* who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a plan or change from one plan to another one time per month;
11. A *qualified individual* or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by Health and Human Services (HHS), that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide;
12. A *qualified individual*, enrollee, or *dependent* is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B–2, and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
13. A *qualified individual* or *dependent* is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 days after the qualifying event; or applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;
14. A *qualified individual* newly gains access to an employer sponsored Individual Coverage Health Reimbursement Arrangement (ICHRA) (as defined in 45 CFR 146.123(b)) or a Qualified Small Employer Health Reimbursement Arrangement (QSHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code);
15. At the option of the Health Insurance Marketplace, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a plan through the Health Insurance Marketplace following termination of enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence; or
16. A *qualified individual* or dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions or government subsidies completely cease.
17. Subject to the availability of enhanced tax subsidies, a *qualified individual* or enrollee, or their *dependent* who is eligible for advance payments of the premium tax credit, and whose household income is expected to be no greater than 150 percent of the Federal poverty level.

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

If you are currently enrolled in Ambetter from Home State Health, please contact Member Services at 1-855-650-3789 TTY 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 enrollee on the date of birth, adoption, placement for adoption, or placement in foster care. In the case of marriage, or in the case where a *qualified individual* loses minimum essential coverage, coverage is effective on the first day of the following month.

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

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

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

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

Prior Coverage

If a *member* is confined as an inpatient in a *hospital* on the *effective date* of this 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 an enrollee from an inpatient hospital stay when the need for continued care at an inpatient hospital has concluded. Transfers from one inpatient hospital to another shall not be considered a discharge.

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

PREMIUMS

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

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

We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period, and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. We will notify Health and Human Services (HHS) of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the second and third month of the grace period. We will continue to collect *advance premium tax credits* on behalf of the *member* from the Department of the Treasury, and will return the *advance premium tax credits* on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above.

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

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

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

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

Reinstatement
If you have coverage purchased outside the Health Insurance Marketplace, and your *contract* lapses due to nonpayment of premium, it may be reinstated provided:

1. We receive from you a written application for reinstatement within one year after the date coverage lapsed; and
2. The written application for reinstatement is accompanied by the required premium payment.

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

The *Rescissions* provision will apply to statements made on the reinstatement application, based on the date of reinstatement. For coverage purchased via the Health Insurance Marketplace, the Health Insurance Marketplace should be contacted for reinstatement.

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

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

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

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

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 a HSA. For members enrolled in an HSA compatible plan, the following terms apply.

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

This Evidence of Coverage is administered by Home State Health and underwritten by Celtic Insurance Company. Neither entity is an HSA trustee, HSA custodian or a designated administrator for HSAs. Celtic Insurance Company, its designee and its affiliates, including Home State Health, do not provide tax, investment or legal advice to members.

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

THE TERMS OF THIS EVIDENCE OF COVERAGE ARE CONFINED TO THE BENEFITS PROVIDED HEREIN AND DO NOT ENCOMPASS ANY INDIVIDIUAL HSA FEE ARRANGEMENTS, ACCOUNT MAINTENANCE OR

CONTRIBUTION REQUIREMENTS, APPLICATION PROCEDURES, TERMS, CONDITIONS, WARRANTIES OR LIMITATIONS THERETO, GRIEVANCES OR CIVIL DISPUTES WITH ANY HSA CUSTODIAN OR TRUSTEE.

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

COST SHARING FEATURES

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

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

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

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

Coinsurance Percentage
A *coinsurance amount* is your share of the cost of a service. *Members* may be required to pay a *coinsurance* in addition to any applicable *deductible amount(s)* due for a *covered service* or supply. *Coinsurance* amounts do not apply toward the *deductible*, but do apply toward your *maximum out-of-pocket amount.*

Maximum Out-of-pocket
You must pay any required *copayments* or *coinsurance* amounts required until you reach the *maximum out-of-pocket amount* shown in your *schedule of benefits*. After the *maximum out-of-pocket amount* is met for an individual, we will pay 100 percent of *eligible service expenses* for that individual. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket* amount. Both the individual and the family *maximum out-of-pocket amounts* are shown in the *schedule of benefits*.

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

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

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

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

The amount payable will be subject to:

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

Please refer to your *Schedule of Benefits* for *coinsurance amounts*, *copayment amounts*, and other limitations.

Non-Network Liability and Balance Billing

If you receive services from a *non-network provider*, you may have to pay more for services you receive. *Non-network providers* may be permitted to bill you for the difference between what 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 in-network costs for the same service and might not count toward your annual *maximum out-of-pocket* limit.

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

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

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

ACCESS TO CARE

Primary Care Physician (PCP)
You may designate a *PCP* for each *member.* You may select any *network PCP* who is accepting new patients. 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 *physician* 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 physicians*. See your *Schedule of Benefits* for more information.

You may obtain a list of *network PCP* at our website and using the "Find a Provider" function or by calling the telephone number shown on the front page of this *contract.*

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

Contacting Your Primary Care Physician (PCP)
To make an appointment with your *PCP*, call their office during business hours and set up a date and time. 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 photo identification. If you need help, call Member Services at 1-855-650-3789 and we will help you make the appointment.

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 1-855-650-3789 (TTY 711). A licensed nurse is always available and ready to answer your health questions. In an emergency, call 911 or head straight to the nearest emergency room.

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

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

Non-Emergency Services
If you are traveling outside of the Home State Health *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 Missouri 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 call us and report your emergency within one business day. You do not need *prior authorization* for emergency care services.

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

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

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

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

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

HOSPITAL BASED PROVIDERS

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

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

MEDICAL EXPENSE BENEFITS

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

The plan provides coverage for health care services for a *member* and/or dependents. Some services require prior authorization.

Copayments, 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 provision of this *contract*. *Covered services* must be *medically necessary* and not experimental or investigational.

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.

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, a skilled nursing facility or any other facility at which appropriate services or therapies may be provided. Service means the work of testing, treatment, and providing therapies to an individual with an *acquired brain injury*. Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an *acquired brain injury*.

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

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

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

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

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

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

Exclusions:
No benefits will be paid for:

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

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

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

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

Limitations: Benefits for air ambulance services are limited to:

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

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

Exclusions:
No benefits will be paid for:

1. Expenses incurred for air ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-emergency 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.

Autism Spectrum Disorder Expense Benefit
Covered service expenses for *autism spectrum disorder* and *developmental or physical disabilities* include *coverage* for both the diagnosis and treatment of them.

For purposes of this section, the following definitions will apply:

Autism service provider means*:*
a. Any person, entity, or group that provides diagnostic or *treatment* services for *autism spectrum disorders* who is licensed or certified by the state of Missouri; or
b. Any person who is licensed under chapter 337 as a board-certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board-certified behavior analyst.

Developmental or physical disability is a severe chronic disability that:
a. Is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness or autism spectrum disorder which results in impairment of general intellectual functioning or adaptive behavior and requires treatment or services;
b. Manifests before the individual reaches age nineteen;
c. Is likely to continue indefinitely; and
d. Results in substantial functional limitations in three or more of the following areas of major life activities:
   1. Self-care;
   2. Understanding and use of language;
   3. Learning;
   4. Mobility;
   5. Self-direction; or
   6. Capacity for independent living.

Diagnosis means medically necessary assessments, evaluations, or tests in order to diagnose whether an individual has an autism spectrum disorder or a developmental or physical disability.

Habilitative or rehabilitative care means professional, counseling, and guidance services and treatment programs, including applied behavior analysis for those diagnosed with autism spectrum disorder, that are necessary to develop the functioning of an individual.

Line therapist is an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment plan, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision

of a licensed behavior analyst.

Pharmacy care means medications used to address symptoms of an autism spectrum disorder or a developmental or physical disability prescribed by a licensed physician, and any health-related services deemed medically necessary to determine the need or effectiveness of the medications only to the extent that such medications are included in the insured's health benefit plan.

Psychiatric care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Psychological care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

Therapeutic care means services provided by licensed speech therapists, occupational therapists, or physical therapists.

Treatment is care prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist, or for an individual diagnosed with a developmental or physical disability by a licensed physician or licensed psychologist, including equipment medically necessary for such care, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, including, but not limited to:

a. Psychiatric care;
b. Psychological care;
c. Habilitative or rehabilitative care, including applied behavior analysis therapy for those diagnosed with autism spectrum disorder;
d. Therapeutic care; and
e. Pharmacy care.

Coverage provided under this section for *autism spectrum disorder* or developmental or physical disabilities is limited to *medically necessary* treatment that is ordered by the insured's treating licensed *physician* or licensed psychologist, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, in accordance with a treatment plan

The *treatment* plan, upon request by the health benefit plan or health carrier, shall include all elements necessary for the health benefit plan or health carrier to pay claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and goals.

Except for inpatient services, if an individual is receiving treatment for an *autism spectrum disorder* or developmental or physical disability, a health carrier shall have the right to review the *treatment* plan not more than once every six months unless the health carrier and the individual's treating *physician* or psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall only apply to a particular individual receiving *applied behavior analysis* and shall not apply to all individuals receiving *applied behavior analysis* from that autism service provider, physician, or psychologist. The cost of obtaining any review or treatment plan shall be borne by the health benefit plan or health carrier, as applicable.

1. Upon request by us, a provider of treatment for *autism spectrum disorders* shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is *medically necessary* and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency,

anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

2. When making a determination of medical necessity for a treatment modality for *autism spectrum disorders*, we will make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under this *contract*, including an *appeals* process. During the *appeals* process, any challenge to *medical necessity* must be viewed as reasonable only if the review includes a *physician* with expertise in the most current and effective treatment modalities for *autism spectrum disorders*. Coverage for *medically necessary* early intervention services must be delivered by certified early intervention specialists.
3. *Habilitation and rehabilitation services*, for *member*s with a diagnosis of *autism spectrum disorder*, shall include: *applied behavior analysis* that is intended to develop, maintain, and restore the functioning of an individual. For physical therapy, speech therapy, or occupational therapy, there is no visit limit when used for the treatment of *Autism Spectrum Disorders*.

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

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

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

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

Clinical Trial Coverage

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

1. The investigational item or service itself:
2. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
3. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Phase I and II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and the insured is enrolled

in the clinical trial. This section shall not apply to insured who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

Clinical trials can be approved if they are approved or funded by one of the following:

1. One of the National Institutes of Health (NIH);
2. The Centers for Disease Control and Prevention;
3. The Agency for Health Care Research and Quality;
4. The Centers for Medicare & Medicaid Services;
5. A cooperative group or center of any of the entities listed above or the Department of Defense or the Department of Veteran Affairs;
6. The FDA in the form of an investigational new drug application;
7. The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
8. The federal Departments of Veterans' Affairs, Defense, or Energy;
9. 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;
10. A qualified non-governmental research entity that meets the criteria for NIH Center support grant eligibility;

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

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

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

Routine Vision Benefits – Adults 19 years of age or older

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

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

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

Services not covered:

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

For additional information about covered vision services, participating vision vendor providers, call Member Services at 1-855-650-3789.

Dental Benefits – Adults 19 years of age or older

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

1. Diagnostic and Preventive Services — Class 1 benefits include:
    a. Routine cleanings;
    b. Oral examinations;
    c. X-rays – bitewing, full-mouth and panoramic film;
    d. Topical fluoride application.
2. Basic Services — Class 2 benefits include:
    a. Minor restorative – metal or resin-based filings;
    b. Endodontics – root canals;
    c. Periodontics – scaling and root planning, periodontal maintenance;
    d. Removeable prosthodontics – relines, rebase, adjustment and repairs;
    e. Extractions – routine and surgical.
3. Major Services —Class 3 benefits include:
    a. Crowns and bridges;
    b. Dentures;
    c. Impactions, complex extractions, and surgical services.

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

Services not covered:

1. Dental services that are not necessary or specifically covered;
2. Hospitalization or other *facility* charges;
3. Prescription drugs dispensed in the dental office;
4. Any dental procedure performed solely as a cosmetic procedure;
5. Charges for dental procedures completed prior to the member's *effective date* of coverage;
6. Services provided by an anesthesiologist;
7. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (wear), abfraction, abrasion, or erosion, realignment of teeth, periodontal splinting, and gnathologic recordings;
8. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles;
9. Any artificial material implanted or grafted into soft tissue or bone, surgical removal of implants, and implant-related services;
10. Sinus augmentation;

11. Surgical appliance removal;
12. Intraoral placement of a fixation device;
13. Oral hygiene instruction, tobacco or nicotine counseling, nutritional counseling, or high-risk *substance use disorder* counseling;
14. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture;
15. Any oral *surgery* that includes surgical endodontics (apicoectomy and retrograde filling);
16. Analgesia (nitrous oxide);
17. Removable unilateral dentures;
18. Temporary procedures;
19. Splinting;
20. Oral pathology laboratory charges;
21. Consultations by the treating provider and office visits;
22. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
23. Veneers (bonding of coverings to the teeth);
24. Orthodontic treatment procedures;
25. Orthognathic *surgery*;
26. Athletic mouth guards; and
27. Space maintainers.

Other Dental Services

Anesthesia and *hospital* charges for dental care, for a *member* less than 19 years of age or a *member* who is physically or mentally disabled, are covered if the *member* requires dental treatment to be given in a *hospital* or outpatient ambulatory surgical *facility*. The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the *member's* condition under general anesthesia.

Coverage is also provided for:

1. For *medically necessary* oral *surgery*, including the following:
   a. Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
   b. Orthognathic *surgery* for a physical abnormality that prevents normal function of the upper and/or lower jaw bone and is *medically necessary* to attain functional capacity of the affected part.
   c. Oral/surgical correction of accidental injuries.
   d. Treatment for Temporomandibular Joint Disorder (TMJ), including removable appliances for TMJ repositioning and related *surgery*, medical care, and diagnostic services.
   e. Treatment of non-dental lesions, such as removal of tumors and biopsies.
   f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
   g. Surgical procedures that are *medically necessary* to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.
   h. *Reconstructive surgery* to correct significant deformities caused by congenital or developmental abnormalities, *illness*, *injury* or an earlier treatment in order to create a more normal appearance.
2. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* or office charges for dental care, rendered by a dentist, regardless of whether the services are provided in a participating hospital, surgical center or office, provided to the following *members*:
   a. A *member* under the age of 19;
   b. a person who is severely disabled; or
   c. a person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.
3. For *dental service expenses* when a *member* suffers an *injury,* that results in:
   a. Damage to his or her natural teeth;
   b. *Injury* to the natural teeth will not include any *injury* as a result of chewing.

4. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, or malocclusions.

Diabetic Care
Benefits are available for *medically necessary* services and supplies used in the treatment of persons with gestational, type I or type II diabetes. The total amount you will be required to pay for a covered insulin drug will not exceed any state and/or federal mandated limits.

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

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

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

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

Durable Medical Equipment, Medical and Surgical Supplies, Orthotic Devices and Prosthetics
The supplies, equipment and appliances described below are *covered services* under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is *medically necessary* in your situation or needed to treat your condition, reimbursement will be based on the maximum allowed amount for a standard item that is a *covered service*, serves the same purpose, and is *medically necessary*. Any expense that exceeds the maximum allowed amount for the standard item which is a *covered service* is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition. Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:
1. The equipment, supply or appliance is a *covered service*;
2. The continued use of the item is *medically necessary*; and
3. There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

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

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

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

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

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

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

Exclusions:
Non-covered items may include but are not limited to:
1. Air conditioners.
2. Ice bags/coldpack pump.
3. Raised toilet seats.
4. Rental of equipment if the *member* is in a *facility* that is expected to provide such equipment.
5. Translift chairs.
6. Treadmill exerciser.
7. Tub chair used in shower.

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.

First Steps Coverage
Covered service expenses include early intervention services described in this section that are delivered by early intervention specialists who are health care professionals licensed by the state of Missouri and acting within the scope of their professions for children from birth to age three identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq.

Such coverage shall be limited to three thousand dollars for each covered child per policy per calendar year, with a maximum of nine thousand dollars per child.

Early intervention services means medically necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology devices for children from birth to age three who are identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq. Early intervention services shall include services under an active individualized family service plan that enhance functional ability without effecting a cure. An individualized family service plan is a written plan for providing early intervention services to an eligible child and the child's family that is adopted in accordance with 20 U.S.C. Section 1436. The Part C early intervention system, on behalf of its contracted regional Part C early intervention system centers and providers, shall be considered the rendering provider of services for purposes of this section.

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

Covered services may include, but are not limited to:
1. Allergy serum extracts.
2. Chem strips, glucometer, lancets.
3. Clinitest.
4. Needles/syringes.
5. Ostomy bags and supplies except charges such as those made by a pharmacy for purposes of a fitting are not *Covered Services*.

6. Disposable medical supplies, which have a primary medical purpose, are covered and are subject to reasonable quantity limits as determined by us. Examples include, but are not limited to: bandages & wraps, gloves, suction catheters, surgical sponges, hypodermic needles, syringes, and applicators. The supplies are subject to the *member's deductible, copayment,* and/or *coinsurance amounts*.

Exclusions:
Non-*covered services* include but are not limited to:

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

Prosthetics
Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. *Covered services* include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

1. Replace all or part of a missing body part and its adjoining tissues; or
2. Replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetic devices should be purchased not rented, and must be *medically necessary*. Applicable taxes, shipping and handling are also covered.

Covered services may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per benefit period, as required by the Women's Health and Cancer Rights Act. Maximums for prosthetic devices, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are *Covered Services*. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract *surgery* or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of *surgery* are not considered contact lenses, and are not considered the first lens following surgery. If the *injury* is to one eye or if cataracts are removed from only one eye and the *member* selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.

8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (not to exceed one per benefit period) when purchased through a *network provider*. This coverage is only provided for *members* who suffer from hair loss as a result of an underlying medical condition, treatment or *injury*. Coverage shall be subject to a written recommendation by the treating *physician* stating that the wig is *medically necessary*.

Exclusions:
Non-covered prosthetic appliances include but are not limited to:
1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Wigs (except as described above).

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

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

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

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

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits
Covered service expenses include expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:
1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must be determined medically necessary.

3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
    a. Daily room and board and nursing services;
    b. Diagnostic testing; and
    c. Drugs and medicines that are prescribed by a *physician*, filled by a licensed pharmacist, and approved by the United States Food and Drug Administration (FDA).
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners.*
5. Coverage for a skilled nursing facility and inpatient *rehabilitation* is subject to a calendar year day limit, as listed in the *schedule of benefits*.
6. Outpatient *habilitation services* are subject to a calendar year visit limit, as listed in the *schedule of benefits* for occupational therapy and physical therapy. There is not a visit limit for speech therapy or any services provided for a substance use disorder or mental health diagnosis, including autism services.
7. Outpatient *rehabilitation* services are subject to a calendar year visit limit, as listed in the *schedule of benefits* for occupational therapy and physical therapy. There is not a visit limit for speech therapy or any services provided for a substance use disorder or mental health diagnosis, including autism services.
8. Coverage for cardiac *rehabilitation*.

See your *schedule of benefits* for benefit levels and applicable limits.

Care ceases to be *rehabilitation* upon our determination of any of the following:
1. The *member* has reached *maximum therapeutic benefit*;
2. Further treatment cannot restore bodily function beyond the level the *member* already possesses;
3. There is no measurable progress toward documented goals; and
4. Care is primarily *custodial care*.

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

Hearing and Communicative Disorders
Necessary care and treatment shall include services to identify, assess, diagnose and consult about the need for treatment and to evaluate and monitor the effectiveness of treatment whether by instrumental, perceptional or standard procedures as well as the provision of treatment for any of the previously mentioned communicative disorders. These services shall include, but not be limited to:
1) Diagnostic and extended evaluation of hearing, which may include pure tone air conduction thresholds, speech thresholds, bone conduction thresholds, prediction of hearing loss from acoustic reflex, reflex eliciting auditory test, communication handicap inventories, word/sentence recognition tests and evoked potential monitoring and testing;
2) Determining range, nature and degree of hearing function related to a patient's auditory efficiency;
3) Comprehensive behavioral evaluation for sensorineural site which includes advanced acoustic reflex tests, tests of auditory adaptation, tests of frequency discrimination and tests of intensity discrimination;
4) Testing, adjusting and evaluating auditory prosthetic devices which may include sound field tests, such as aided word/sentence recognition, real ear measures, warble tone thresholds, narrow band noise thresholds, and comfortable and uncomfortable loudness levels while wearing an auditory prosthesis;
5) Differentiation between organic and nonorganic hearing disabilities through evaluation of total response pattern and use of acoustic tests;
6) Planning, directing, conducting or participating in conservation, habilitative and rehabilitative

programs including *hearing aid* selection and orientation, counseling, guidance, auditory training, speech reading, language *habilitation* and speech conservation;

7) Coordinating and consulting with educational, medical and other professional groups, and with patients and their families;
8) Diagnosing and evaluating speech and language competencies of individuals, including assessment of speech and language skills as related to educational, medical, developmental, social and psychological factors;
9) The services enumerated in paragraphs (2)(B)1.-8 shall be designed to evaluate and treat individuals to develop or utilize speech, language and other communicative skills to the maximum extent possible to remedy any loss or impairment for which services are being provided. However, nothing in this rule shall be construed to require services to improve public speaking, care of the professional voice or accent reduction;
10) Cognitive training secondary to open or closed head injury, regardless of cause;
11) Assisting individuals with voice disorders to develop proper control of the vocal and respiratory systems for correct voice production;
12) Evaluating and treating children with delayed or impaired speech or language disorders;
13) Determining the need for augmentative/prosthetic communication systems whether or not that system or that device replaces a body part. These systems or devices may include, but are not limited to, sign language, gesture systems, communication boards, electronic automated devices, mechanical devices, alaryngeal prosthesis, palatal prosthesis and synthetic voice systems; and
14) Planning, directing, or conducting habilitative and rehabilitative treatment programs to restore or provide communicative efficiency to individuals with communication problems of organic and nonorganic etiology, such as partial to total glossectomy, partial to total laryngectomy, or both; and
    a. Other *covered services* shall mean any other *medically necessary* medical or health care services, or both, for which coverage is provided whether or not for acute conditions, provided while a patient in a hospital, or provided by or in a *rehabilitation* center, skilled nursing *facility*, clinic, home health agency or community-based program. This means that limitations on coverage may not be specific to speech, language and hearing disorders or for services rendered by speech language pathologists and audiologists.
    b. The communicative disorders generally treated by speech/language pathologists and audiologists shall include, but not be limited to, aphasia; motor speech disorders; delayed speech or language ability; total or partial speech or language loss or deficit; swallowing disorders; total or partial hearing loss or deficit; disorders of verbal and written language, articulation, voice, fluency, mastication, deglutition, cognition, auditory or visual processing and memory, and interactive communications; and disorders of air conduction, bone conduction, word/sentence recognition and acoustic impedance.

Hearing Aids

One pair of hearing aids is covered each year, regardless of *member's* age. Expenses for these services are covered if *medically necessary* and may be subject to prior *authorization*. Please see your *Schedule of benefits* for more information regarding services that require *prior authorization*.

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 in a medical office. Coverage is provided for *medically necessary network* care provided at the *member's* home and includes the following:

1. *Home health aide services*;
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care;*
3. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to your *schedule of benefits* for any limits associated with this benefit.

4. Intravenous medication and pain medication;
5. Hemodialysis, and for the processing and administration of blood or blood components;
6. *Medically necessary medical supplies*; and
7. Rental of *medically necessary durable medical equipment.*

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

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

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

Hospice Care Service Expense Benefits
This provision only applies to a *terminally ill member* receiving *medically necessary* care under a *hospice care program* or in a home setting. *Respite care* is covered on an *inpatient or home basis* to allow temporary relief to family members from the duties of caring for a *member* who is undergoing *hospice* care. Respite days that are applied toward the member's *deductible amount* are considered benefits provided and shall apply against any *maximum benefit* limit for these services. See your *Schedule of Benefits* for coverage limits.

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

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

Exclusions and Limitations:
Any exclusion or limitation contained in the *contract* regarding:
1. An *injury* or *illness* arising out of, or in the course of, employment for wage or profit;
2. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice care program;* or
3. Expenses for other persons, to the extent those expenses are described above, will not be applied

to this provision.

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* for use only while you are *inpatient.*
7. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See your *schedule of benefits* for limitations.

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

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

- Complex wound care:
  - Daily physician monitoring of wound
  - Wound requiring frequent complicated dressing changes, and possible repeated debridement of necrotic tissue
  - Large wound with possible delayed closure, draining, and/or tunneling or high output fistulas
  - Lower extremity wound with severe ischemia
  - Skin flaps and grafts requiring frequent monitoring
- Infectious disease:
  - Parenteral anti-infective agent(s) with adjustments in dose
  - Intensive sepsis management
  - Common conditions include osteomyelitis, cellulitis, bacteremia, endocarditis, peritonitis, meningitis/encephalitis, abscess and wound infections
- Medical complexity:
  - Primary condition and at least two other actively treated co-morbid conditions that require monitoring and treatment
  - Common conditions include metabolic disorders, stroke, heart failure, renal insufficiency, necrotizing pancreatitis, emphysema (COPD), peripheral vascular disease, and malignant/end-stage disease
- Rehabilitation:
  - Care needs cannot be met in a rehabilitation or skilled nursing facility
  - Patient has a comorbidity requiring acute care
  - Patient is able to participate in a goal-oriented rehabilitation plan of care
  - Common conditions include CNS conditions with functional limitations, debilitation, amputation, cardiac disease, orthopedic surgery
- Mechanical ventilator support:
  - Failed weaning attempts at an acute care facility
  - Patient has received mechanical ventilation for 21 consecutive days for 6 hours or more/day
  - Ventilator management required at least every 4 hours as well as appropriate diagnostic services and assessments

- Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions
- Patient is hemodynamically stable and not dependent on vasopressors
- Respiratory status is stable with maximum PEEP requirement 10 cm H2O, and FiO2 60% or less with O2 saturation at least 90%
- Common conditions include complications of acute lung injury, disorders of the central nervous and neuromuscular systems, and cardiovascular, respiratory, and pleural/chest wall disorders
- Patient continues to meet the criteria above and does not meet the criteria to be transitioned to alternate level of care.

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

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*.

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

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

Mammography Coverage
"Mammogram" includes low-dose *mammography* screening, digital *mammography* and breast tomosynthesis. Low-dose mammography screening means the X-ray examination of the breast using equipment specifically designed and dedicated for mammography, including the X-ray tube, filter, compression device, detector, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast, and any fee charged by a radiologist or other physician for reading, interpreting or diagnosing based on such X-ray. The term "low-dose mammography screening" shall also include digital mammography and breast tomosynthesis. The term "breast tomosynthesis" shall mean a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

The following services are covered.
1. A baseline mammogram for women age 35 to 39, inclusive;
2. A mammogram every year for women age forty and over;

3. A mammogram every year for any woman deemed by a treating *physician* to have an above-average risk for breast cancer in accordance with the American College of Radiology guidelines for breast cancer screening;
4. Any additional or supplemental imaging, such as breast magnetic resonance imaging or ultrasound, deemed *medically necessary* by a treating *physician* for proper breast cancer screening or evaluation in accordance with applicable American College of Radiology guidelines; and
5. Ultrasound or magnetic resonance imaging services, if determined by a treating *physician* to be *medically necessary* for the screening or evaluation of breast cancer for any woman deemed by the treating *physician* to have an above-average risk for breast cancer in accordance with American College of Radiology guidelines for breast cancer screening.

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

Mental health services will be provided on an *inpatient* and *outpatient* basis and include mental disorders. These disorders affect the *member'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* and *substance use disorder* network. You can search for *network behavioral health* providers by using our Find a Provider tool at Ambetter.homestatehealth.com or by calling Member Services at 855-650-3789 (TTY 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 *member*s for the diagnosis and *medically necessary* treatment of mental, emotional, or *substance use disorders*, including *autism spectrum disorders* as defined in this policy.

When making coverage determinations, our Utilization Management staff employ established level of care guidelines and *medical necessity* criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. They utilize Change Healthcare InterQual criteria for mental health determinations and ASAM American Society of Addiction Medicine (ASAM) criteria for *substance use disorder* determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

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

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

Outpatient
1. Partial Hospitalization Program (PHP);
2. Intensive *Outpatient* Program (IOP);
3. *Outpatient* detoxification programs;
4. Evaluation and assessment for mental health* and substance use disorders;

5. Individual and group therapy for mental health and substance use;
6. Medication Assisted Treatment- combines behavioral therapy and medications to treat *substance use disorders*;
7. Medication management services;
8. Psychological and Neuropsychological testing and assessment;
9. *Applied Behavioral Analysis for* treatment *of autism*;
10. Mental Health day treatment;
11. Telehealth*;*
12. Electroconvulsive Therapy (ECT);
13. *Transcranial Magnetic Stimulation (TMS)*; and
14. Assertive Community Treatment (ACT).

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

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

In addition, Integrated *Care Management* is available for all of your health care needs, including *behavioral health* and *substance use disorders*. Please call 855-650-3789 (TTY 711) to be referred to a care manager for an assessment.

*Note: This health benefit plan requires that all health care services be delivered by a participating provider in our network. Services rendered by an out-of-network provider are not covered under this plan, except for emergency services and two (2) sessions per year to a licensed psychiatrist, licensed psychologist, licensed professional counselor, or a licensed clinical worker for the purpose of diagnosis or assessment of mental health.

Medical Foods
We cover medical foods and formulas for outpatient total parenteral therapy, outpatient enteral therapy, outpatient elemental formulas for malabsorption, and dietary formula when medically necessary for the treatment of Phenylketonuria (PKU) and inborn errors of metabolism. Coverage for inherited diseases of amino acids and organic acids shall, in addition to the enteral formula, include food products modified to be low protein. Such coverage shall be provided when the prescribing *physician* has issued a written order stating that the enteral formula or food product is *medically necessary*.

Excluded are any other non-medical dietary formulas, oral nutritional supplements, special diets, prepared foods or meals, baby formula or food and formula for access problems.

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

Chiropractic Services
We cover charges for chiropractic services. These services will be covered for a *member* who presents a condition of an orthopedic or neurological nature necessitating treatment for which falls within the scope of a licensed chiropractor.

Medical and Surgical Expense Benefits
Medical *covered service expenses* are limited to charges:

1. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies.
2. For dressings, crutches, orthopedic splints, braces, casts, or other *medically necessary medical supplies.*
3. For diagnostic testing using radiologic, ultrasonographic, or laboratory services.
4. For chemotherapy and radiation therapy or treatment.
5. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
6. For the cost and administration of an anesthetic.
7. For oxygen and its administration.
8. 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.
9. For chiropractic care, including office visits for assessment, evaluation, spinal adjustment, *medically necessary* manipulative therapy treatment on an outpatient basis and physiological therapy before (or in conjunction with) spinal adjustment up to the calendar year visit limit; visits in excess of the calendar year limit will require *prior authorization.* Please refer to your *schedule benefits* for applicable calendar year limits.
10. For pulse oximetry screening on a newborn.
11. Well Child care examinations for children through the age of 12, including child health supervision services, based on American Academy of Pediatric Guidelines.
12. For *medically necessary* human organ and tissue transplants.
13. Family Planning for certain professional provider contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.
14. For treatment received outside the United States while traveling for up to a maximum of 90 consecutive days.
15. Newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.
16. Allergy testing, injections and serum.
17. 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.
18. 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.

19. For cancer screenings, as follows:
    a. A pelvic examination and pap smear for any non-symptomatic woman who is a *member*, in accordance with the current American Cancer Society guidelines;
    b. A prostate examination and laboratory tests for cancer for any non-symptomatic man who is a *member*, in accordance with the current American Cancer Society guidelines; and
    c. A colorectal cancer examination and laboratory tests for cancer for any non-symptomatic *member*, in accordance with the current American Cancer Society guidelines.
20. For telehealth for *covered services* provided within the scope of practice of a *physician* or other healthcare provider as a method of delivery of *medical care* by which a *member* shall receive medical services from a healthcare provider without in-person contact with the provider.
21. For respiratory and pulmonary therapy.
22. For *medically necessary* genetic blood tests.
23. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).
24. Services related to diagnosis, treatment and appropriate management of osteoporosis when such services are provided by a person licensed to practice medicine and surgery in the state, if the member has a condition or medical history for which bone mass measurement is medically indicated.
25. Infusion therapy.
26. Testing of pregnant women and other *members* for lead poisoning.
27. *Medically necessary* routine footcare; prior authorization may be required.

Outpatient Medical Supplies Expense Benefits

Covered service expenses for miscellaneous *outpatient* medical services and supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs (but not the replacement thereof, unless required by a physical change in the *member* and the item cannot be modified). If more than one *prosthetic device* can meet a *member's* functional needs, only the charge for the most cost effective *prosthetic device* will be considered a *covered service expense*.
2. For one pair of foot orthotics per *member*. 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 cost of one Continuous Passive Motion (CPM) machine per *member* following a covered joint *surgery*.
5. For one pair of eyeglasses or contact lenses per *member* following a covered cataract *surgery*.

Maternity Care

An inpatient stay is covered for mother and newborn for a minimum of 48 hours following a vaginal delivery and 96 hours following a delivery by cesarean section. We do not require that a *physician* or other healthcare provider submit the *prior authorization* prior to the delivery, however the physician or other health care provider must notify us upon admission. An inpatient stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require notification to the health plan.

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 document for details regarding *coverage* for a newborn child/coverage for an adopted child.

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

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

b. *Physician* home visits and office services.
c. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
d. *Complications of pregnancy*.
e. *Hospital* stays for other *medically necessary* reasons associated with maternity care.

Note: This provision does not amend the *contract* to restrict any terms, limits, or conditions that may otherwise apply to *covered service expenses* for maternity care. This provision also does not require an enrollee who is eligible for coverage under a health benefit plan to:

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

Maternity coverage of a home birth by a midwife or nurse midwife is limited to low risk *pregnancy* and may be subject to *prior authorization* requirements.

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

Post-Discharge Care
Post-discharge care that includes home visits requires *prior authorization*. It may consist of a visits in the home, , in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. The location and schedule of the post-discharge visits shall be determined by the attending physician. Services provided by the registered professional nurse or *physician* shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. Any abnormality, in the condition of the mother or the child, observed by the nurse shall be reported to the attending *physician* as medically appropriate.

Duty to Cooperate
We do not cover services or supplies related to a *member's* pregnancy when a *member* is acting as a *surrogate* and has entered into a *surrogacy arrangement*. For more information on excluded services, please see the General Non-Covered Services and Exclusions section. *Members* who are a *surrogate* at the time of enrollment or *members* who agree to a *surrogacy arrangement* during the plan year must, within 30 days of enrollment or agreement to participate in a *surrogacy arrangement*, send us written notice of the *surrogacy arrangement* to Ambetter from Home State Health at the Member Services Department, 7711 Carondelet Ave., St. Louis, MO, 63105. In the event that a *member* fails to comply with this provision, we reserve our right to enforce this EOC on the bases of fraud, misrepresentation or false information, up to and including recoupment of all benefits that we paid on behalf of the *surrogate* during the time that the *surrogate* was insured under this *contract*, plus interest, attorneys' fees, costs and all other remedies available to us.

Newborns' and Mothers' Health Protection Act Statement of Rights
If expenses for *hospital* confinement in connection with childbirth are otherwise included as *covered service expenses*, we will not limit the number of days for these expenses to less than that stated in this provision.

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any

hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, we may provide benefits for *covered service expenses* incurred for a shorter stay if the attending provider (e.g., your *physician*, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

Prescription Drug Expense Benefits
We work with providers and pharmacists to ensure that we cover medications used to treat a variety of conditions and diseases.
Covered service expenses in this benefit subsection are limited to charges from a licensed *pharmacy* for:

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

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

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

The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her *physician.* If we change our formulary we will provide you with notification of the change electronically, or in writing, upon your request, at least 30 days in advance of the change. If the dosage of a prescription is such that two different manufactured dosage amounts are required, and you pay your *copay* for both dosages, you may submit the claims to us for reimbursement of the additional *copay*.

Formulary or Prescription Drug List
The formulary or *prescription drug* list is a guide to available generic and brand name drugs, as well as some over-the-counter medications when prescribed by a physician, that are approved by the Food and Drug Administration (FDA) and covered through your *prescription drug* benefit. Generic drugs have the same active ingredients as their brand name counterparts and should be considered the first line of treatment. The FDA requires generics to be safe and work the same as brand name drugs. If there is no generic available, there may be more than one brand name drug to treat a condition. Preferred brand name drugs

are listed on Tier 2 of the Drug List to help identify brand name drugs that are clinically appropriate, safe and cost effective treatment options, if a generic medication on the formulary is not suitable for your condition.

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

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the formulary. For the most current Ambetter formulary or *prescription drug* list or for more information about our pharmacy program, visit Ambetter.homestatehealth.com (under "For Member", "Drug Coverage") or call Member Services at 855-650-3789 (TTY 711).

Non-Covered Services and Exclusions:

No benefits will be paid under this benefit provision for services provided or expenses incurred:

1. For *prescription drug* treatment of erectile dysfunction or any enhancement of sexual performance unless such treatment is listed on the formulary.
2. For weight loss prescription drugs unless otherwise listed on the formulary.
3. For immunization agents otherwise not required by the Affordable Care Act.
4. For medication that is to be taken by the *member*, in whole or in part, at the place where it is dispensed.
5. For medication received while the *member* is a patient at an institution that has a *facility* for dispensing pharmaceuticals.
6. For a refill dispensed more than 12 months from the date of a *physician's* order.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are listed on the formulary.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For 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 maintenance drugs up to a 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply network. Specialty drugs and other select drug categories are limited to 30-day supply when dispensed by retail or mail order. 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 section does not prohibit coverage of treatment for aforementioned diseases.
15. For medications used for cosmetic purposes.
16. For infertility drugs unless otherwise listed on the formulary.
17. For any drug related to surrogate pregnancy.
18. For any controlled substance that exceeds state established maximum morphine equivalents in a

particular time period, as established by state laws and regulations.

19. For drugs or dosage amounts determined by Ambetter's Pharmacy and Therapy committee to be ineffective, unproven, or unsafe for the indication for which they have been prescribed, regardless of whether such drugs or dosage amounts have been approved by any governmental regulatory body for that use.
20. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
21. For any claim submitted by non-lock-in pharmacy while member is in lock-in status.
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. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
24. Compound drugs unless there is at least one ingredient is an FDA approved drug.

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

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

Standard exception request

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

Expedited exception request

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

External exception request review

If we deny a request for a standard exception or for an expedited exception, the *member*, the *member's authorized representative* or the *member's* prescribing *physician* may request that the original exception request and subsequent denial of such request be reviewed by an external review organization. We will make our determination on the external exception request and notify the *member*, the *member's authorized representative* or the *member's* prescribing *physician* of our coverage determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception.

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

Drug discount, Coupon or Copay Card
Cost sharing paid on your behalf for any prescription drugs obtained by you through the use of a drug discount, coupon, or *copay* card provided by a *prescription drug* manufacturer will not apply toward your plan *deductible* or your maximum out of pocket.

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

Over-the-Counter (OTC) Prescriptions
We cover a variety of over-the-counter (OTC) medications when ordered by a physician. You can find a list of covered over-the-counter medications in our formulary – they will be marked as "OTC". Your *prescription order* must meet all legal requirements.

How to Fill a Prescription
Prescription orders can be filled at a network retail pharmacy or through our mail order pharmacy.

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

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

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

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.

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

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

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

Services not covered:

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

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

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

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

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

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

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

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

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

Notification

As required by section 2715(d)(4) of the Public Health Service Act, we will provide 60 days advance notice to you before any material modification will become effective, including any changes to preventive benefits covered under this contract. You may access our website or the Member Services Department at 1-855-650-3789 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 ambetter.homestatehealth.com.

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 *physician* of the *member's* choice. The *member* may select a *network provider* listed in the Provider Directory. If a *member* chooses a *network provider*, he or she will only be responsible for the applicable *cost sharing* for the consultation. Any lab tests and/or diagnostic and therapeutic services are subject to the additional *cost sharing*. If the *member* chooses a non-network provider, that provider may request a *prior authorization*, but *approval* is not guaranteed.

Transplant Expense Benefits

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

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 the *member's* benefits.
3. If *you* are the donor for the transplant and no coverage is available to *you* from any other source, the benefits under this *policy* will be provided for you. However, no benefits will be provided for the recipient.
4. If lapse in coverage due to non-payment of premium, no services related to transplants will be paid as a *covered service*.

If we determine that a *member* and donor are an appropriate candidate for a *medically necessary* transplant, live donation, *covered service expenses* will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting of the organ from the donor.
3. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
4. Including outpatient *covered services* related to the transplant *surgery*; pre-transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection, and other immunosuppressant drug therapy, etc. Also included is the cost for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. Coverage is limited to a maximum cost of $75 per transplant.
5. Pre-transplant stabilization, meaning an *inpatient* stay to *medically stabilize* a *member* to prepare for a later transplant, whether or not the transplant occurs.
6. The transplant itself, including the acquisition cost for the organ or bone marrow when *authorized* through the *Center of Excellence* and services are performed at a 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 at https://ambetter.homestatehealth.com/content/ambetter-mo/en_us/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 *medically necessary* transplant from any *physician*. However, if a *medically necessary* transplant is performed in a *Center of Excellence:*

1. We will pay for the following services when the *member* is required to travel more than 75 miles from the *residence* to the *Center of Excellence*.
2. We will pay a maximum of $10,000 per transplant for the following services:
    a. Transportation for the *member,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence* in the United States.
    b. When the *member* and/or donor is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
    c. Maximum reimbursement for mileage is limited to travel to and from the *member's* home to the transplant facility, and to and from the donor's home to the transplant facility, and will be reimbursed at the current IRS mileage standard for miles driven for medical purposes.
    d. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence* in the United States. We will reimburse *members* for the proof of costs directly related for transportation, lodging and any of the following approved items listed in the *member* transplant reimbursement guidelines. However, you must make the arrangements and provide the necessary paid receipts for reimbursement within 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.

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

Non-Covered Services and Exclusions:

No benefits will be provided or paid under these Transplant Expense Benefits:

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

a. Alcohol/tobacco
b. Car rental (unless pre-approved by Case Management)
c. Vehicle maintenance for motorized, hybrid, and electric cars (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.)
d. Parking, such as but not limited to hotel, valet or any offsite parking other than hospital.
e. Storage rental units or temporary housing incurring rent/mortgage payments
f. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
g. Speeding tickets
h. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
i. For any services related to pet care, boarding, lodging, food, and/or travel expenses; other than those related to certified/registered service animal(s).
j. Expenses for persons other than the patient and his/her covered companion
k. Expenses for lodging when *member* is staying with a relative
l. Any expense not supported by a receipt
m. Upgrades to first class travel (air, bus, and train)
n. Personal care items (e.g., shampoo, deodorant, clothes)
o. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA pre-check, and early check-in boarding fees, extra baggage fees
p. Souvenirs (e.g., t-shirts, sweatshirts, toys)
q. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type
r. All other items not described in the policy as *eligible service expenses*

11. 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.

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

If you have a medical condition that may prohibit you from participating in these programs, we may require you to provide verification, such as an affirming statement from your physician, that your medical condition makes it unreasonably difficult or inadvisable to participate in the wellness or health improvement program, in order for you to receive the reward or incentive.

You may obtain information regarding the particular programs available at any given time by visiting our website at Ambetter.HomestateHealth.com or by contacting Customer Service by telephone at 855-650-3789 (TTY 711). The benefits are available as long as coverage remains active, unless changed by us as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All enrollees are eligible for program benefits upon obtaining coverage. The programs are optional, and the benefits are made available at no additional cost to the enrollees. The programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change by us through updates available on our website or by contacting us.

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

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

Your care manager will work with you and your doctor to help you get the care you need. If you have a severe medical condition, your care manager will work with you, your *PCP* and other providers to develop a care plan that meets your needs and your caregiver's needs. If you think you could benefit from our *Care management* program, please call Member Services at 855-650-3789 (TTY 711).

Social Determinants of Health Supplemental Benefits
Social determinants of health supplemental benefits and services may be offered to enrollees to remove barriers to accessing health services and improve overall health outcomes. These are benefits and services that we may make available in connection with this *contract*. The benefits and services provided may include transportation to health services, assistance with childcare, access to healthy meals, and other relevant services based on need. The benefits are available as long as coverage remains active, unless changed by us.

Upon termination of coverage, the benefits are no longer available. All enrollees are automatically eligible for the benefits upon obtaining coverage. The services are optional, and the benefits are made available at no additional cost to the enrollees. The benefits and services available at any given time are made part of this *contract* by this reference and are subject to change by us through an update to information available on our website or by contacting us.

Social determinants of health benefits and services may be offered to enrollees through the "My Health Pays" wellness program and through our websites. Enrollees may receive notifications about available benefits and services through emails from local health plans and/or through the "My Health Pays" notification system. To inquire about these benefits and services or other benefits available, you may visit our website at Ambetter.HomestateHealth.com or by contacting Member Services at 1-855-650-3789 (TTY 711).

Urgent Care Service Benefits
Urgent care services include *medically necessary* services by *network and non-network physicians* and services provided at a*n urgent care center* including *facility* costs and supplies. Care that is needed after a *primary care physician'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 facility*.

Members are encouraged to contact their *primary care physician* for an appointment before seeking care from another *physician*, but *urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *primary care physician* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-855-650-3789 (TTY 711). The 24/7 Nurse Advice Line is available 24 hours a day, seven days a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

Emergency Room Services

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

Note: For unanticipated or emergency health care services received in a network *facility* from a *non-network provider*, from the time you present an *emergency medical condition* until the time of discharge you will only be responsible for your standard cost sharing amount. For services received in a non-network *facility*, you may be billed for the difference between the amount paid and the *non-network provider's* charge.

UTILIZATION REVIEW (AUTHORIZATION)

Prior Authorization Required
Some medical and *behavioral health covered services* require *prior authorization*. In general, *network providers* must obtain *prior authorization* from us prior to providing a *network eligible service* or supply to a *member.* However, there are some cases in which you must obtain the *prior authorization*. For example, if you*:*

1. Wish to receive a service or supply from a *non-network provider;* or
2. Are admitted into a *network facility* by a *non-network provider;* or
3. Are requesting a *non-covered service*

It is recommended that all services be provided by *network providers*. If you receive services from a *non-network provider*, or services that are not covered, and you do so without first obtaining *prior authorization*, you may be liable for all expenses.

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 must be obtained for the following services, except for Urgent Care or Emergency Services. This list is not exhaustive. To confirm if a specific service requires *Prior Authorization*, please contact Member Services.

a. Non-emergency health care services provided by *non-network providers*;
b. Reconstructive procedures;
c. Diagnostic Tests such as specialized labs, procedures and high technology imaging;
d. Injectable drugs and medications;
e. Inpatient Health Care Services;
f. Specific surgical procedures;
g. Nutritional supplements;
h. Pain management services; and
i. Transplant services.

Prior authorization requests (medical and *behavioral health*) can be submitted by your provider electronically or via telephone, eFax, or provider web portal. Although not required, submitting requests within the recommended timeframes below will allow for timely review of *prior authorization* requests:

1. At least five days prior to an elective admission as an *inpatient* in a hospital, extended care or *rehabilitation facility*, *hospice facility* or *residential treatment facility*.
2. At least 30 days prior to the initial evaluation for organ transplant services.
3. At least 30 days prior to receiving clinical trial services.
4. Within 24 hours of any inpatient admission, including emergent inpatient admissions.
5. At least five 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 necessary information, including the results of any face-to-face clinical evaluation or second opinion that may be required has been submitted, we will notify you and your provider if the request has been approved as follows:

1. For immediate or urgent request situations, within sixty (60) minutes, when the lack of treatment may result in an *emergency* room visit or *emergency* admission.
2. For non-urgent pre-service requests regarding proposed admission, procedure or service within 36 hours, which shall include one business day of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination.
3. For post-service requests and *retrospective reviews*, we will make our determination within 30 calendar days of receipt of the request. We will notify you in writing of the determination within ten days of making the determination.

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

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

Failure to Obtain Prior Authorization
Network providers cannot bill you for services for which they fail to obtain *prior authorization* as required. In cases of emergency, benefits will not be reduced for failure to comply with *prior authorization* requirements*.* However, you must contact us as soon as reasonably possible after the *emergency* occurs.

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

Payment for authorized services may be denied, and an authorization may be rescinded, if:

1. Such authorization is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition; or
2. The health benefit plan terminates before the health care services are provided; or
3. The *member's* coverage under the health benefit plan terminates before the health care services are provided.

If all terms and conditions of the *contract* are met and we authorize a proposed admission, treatment, or *covered service* expense by a health care provider based upon the complete and accurate submission of all necessary information relative to an eligible member, we shall not retroactively deny, revoke, or restrict this authorization within 45 business days if the health care provider renders the *covered service* expense in good faith and pursuant to the authorization.

Notice of Prior Authorization
If a *prior authorization* request is approved, the provider will be informed of the *approval* by telephone or electronically within 24 hours of making the decision. The *member* will be informed within two business days of the decision being made, and written or electronic confirmation of the telephone notification will be provided to the *member* and the provider within two business days of making the *adverse determination*.

A Notice of *prior authorization* includes:

1. The number of certified days of *hospital* confinement;
2. The medical diagnosis, and if applicable, the *surgical procedure* that was certified;
3. Instructions for a *physician* to request additional days of *hospital* confinement (if necessary); and
4. Instructions regarding questions about the *authorization* process.

Notice of Adverse Determination

If treatment is not medically appropriate and medically necessary, the provider will be informed of the *adverse determination* by telephone within twenty-four hours of making the *adverse determination*, and written or electronic confirmation of the telephone notification will be provided to the *member* and the provider within one business day of making the *adverse determination*.

The written notification of an *adverse determination* will include the principal reason or reasons for the determination, including the clinical rationale, and the instructions for initiating an *appeal* or reconsideration of the determination. We will provide the clinical rationale in writing for an *adverse determination*, including the clinical review criteria used to make that determination, to the health care provider and to any party who received notice of the *adverse determination*.

If a *member* decides to receive non-certified medical treatment, then no benefits are paid. The *member* may elect to file an *Appeal* with us. At all times, the final decision for actual medical treatment to be provided is the right and responsibility of the *member* and the *physician*.

Initial Concurrent Review Determinations

For concurrent review determinations, a determination will be made within one business day of obtaining all necessary information. In the case of a determination to certify an extended stay or additional services, the provider rendering the service will be notified by telephone within one business day of making the *authorization*, and written or electronic confirmation of the telephone notification will be provided to the *member* and the provider within one business day after the telephone notification. The notification will include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

In the case of an *adverse determination*, the provider rendering the service will be notified by telephone within twenty-four hours of making the *authorization*, and written or electronic confirmation of the telephone notification will be provided to the *member* and the provider within one business day after the telephone notification. In any case, services will be continued without liability to the *member* until the *member* has been notified of a determination.

Ongoing Continued Stay 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 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 the claimant 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 *pre-service 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.

Retrospective Review Determinations
For *retrospective review* determinations, a determination will be made within 30 calendar days of receiving all necessary information. A written notice of the determination will be provided to the *member* within ten business days of making the determination.

Reconsideration of Determination
In a case involving an initial determination or a concurrent review determination, the provider rendering the service may request on behalf of the *member* a reconsideration of an *adverse determination* by the reviewer making the *adverse determination*. The reconsideration will occur within one business day of the receipt of the request and will be conducted between the provider rendering the service and the reviewer who made the *adverse determination* or a clinical peer designated by the reviewer if the reviewer who made the *adverse determination* is not available within one business day. If the reconsideration process does not resolve the difference of opinion, the *adverse determination* may be appealed by the *member* or the provider on behalf of the *member*. Reconsideration is not a prerequisite to a standard *appeal* or an expedited *appeal* of an *adverse determination*.

Notification
It is your responsibility to notify us and arrange for the release of necessary medical information from your *physician* to the Utilization Review Organization. You may also arrange for the *hospital* or your *physician* to notify the Utilization Review Organization; however, if for any reason your *physician* or *hospital* fails to cooperate, the penalty applies as described in the "Failure to Obtain *Prior Authorization*" provision of this section.

Notification is required for all *hospital confinements*, psychiatric care, *outpatient surgeries*, *major diagnostic tests*, *home health care*, *extended care facility* confinements, *hospice services, rehabilitation facility* confinements, *skilled nursing facilities* and transplants. Notification MUST take place at least two weeks prior to the scheduled confinement, *treatment* or service.

Services from Non- Network Providers
Except for emergency medical services, we do not normally cover services received from *non-network providers*. If a situation arises where a *covered service* cannot be obtained from a *network provider* located within a reasonable distance, we may provide a *prior authorization* for you to obtain the service from a

non-network provider at no greater cost to you than if you went to a *network provider*. If *covered services* are not available from a *network provider*, you or your *PCP* must request *prior authorization* from us before you receive services from a *non-network provider*. Otherwise, you will be responsible for all charges incurred.

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/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 this *contract.* You will be fully responsible for payment for any services that are not *covered service expenses.*
5. Any services where other coverage is primary to Ambetter must be first paid by the primary payor prior to consideration for coverage under Ambetter.
6. Any non-medically necessary court ordered care for a medical/surgical or mental health/*substance use disorder* diagnosis, unless required by state law.

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract.*
2. For any portion of the charges that are in excess of the *eligible service expense.*
3. For weight modification, bariatric *surgery*, or for surgical *treatment* of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery* and weight loss programs, except as specifically covered in this *contract.*
4. For breast reduction or augmentation.
5. For the reversal of sterilization and the reversal of vasectomies. Reversal of non-elective sterilizations resulting from *illness* or *injury* is covered.
6. For abortion (unless abortion is necessary to save the life of the *member*, or as required by *applicable law*).
7. For artificial insemination (AI), assisted reproductive technology (ART) procedures or the diagnostic tests and drugs to support AI or ART procedures.
8. For expenses for television, telephone, or expenses for other persons.
9. For marriage, family, or child counseling for the *treatment* of premarital, marriage, family, or child relationship dysfunctions.
10. For telephone consultations between providers, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
11. For stand-by availability of a *medical practitioner* when no *treatment* is rendered.
12. For *dental service expenses,* including braces for any medical or dental condition, *surgery* and *treatment* for oral *surgery*, except as expressly provided for under Medical Service Benefits.
13. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under this *contract* or is performed to correct a birth defect.
14. For cosmetic breast reduction or augmentation, except for the *medically necessary treatment* of Gender Dysphoria.
15. For diagnosis or treatment of nicotine addiction, except as otherwise covered as part of preventive care.

16. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Expense Benefits.
17. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
18. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
19. For vocational or recreational therapy, vocational *rehabilitation*, *outpatient* speech therapy, or occupational therapy, except as expressly provided for in this *contract.*
20. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
21. For the *treatment* of infertility except as expressly provided in this *contract.*
22. 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.
23. For *treatment* received outside the United States, except for a medical *emergency* while traveling for up to a maximum of 180 consecutive days. If travel extends beyond 180 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 180 days.
24. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
25. For fetal reduction *surgery*.
26. Except as specifically identified as a *covered service expense* under the *contract*, services or expenses for alternative *treatments*, including acupressure, acupuncture, aroma therapy, dry needling, hypnotism, massage therapy, rolfing, and other forms of alternative *treatment* as defined by the Office of Alternative Medicine of the National Institutes of Health.
27. As a result of any *injury* sustained while at a *residential treatment facility.*
28. 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.
29. For the following miscellaneous items: artificial insemination (except where required by federal or state law); blood and blood products; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods provision; ; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *rehabilitation* services for the enhancement of job, athletic or recreational performance; routine or elective care outside the *service area*; *treatment* of spider veins; transportation expenses, unless specifically described in this *contract.*
30. For court ordered testing or care unless *medically necessary*.
31. Domiciliary care provided in a residential institution, *treatment* center, halfway house, or school because a *member's* own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
32. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.

33. Services or supplies eligible for payment under either federal or state programs (except Medicaid). This exclusion applies whether or not you assert your rights to obtain this coverage or payment of these services.
34. Biofeedback.
35. Mental Health Services are excluded:
    (a) Evaluation for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless a *network provider* determines such evaluation to be *medically necessary*.
    (b) When ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless a *network provider* determines such services to be *medically necessary*.
    (c) Court-ordered testing and testing for ability, aptitude, intelligence or interest.
    (d) Services which are custodial in nature.
36. *Surrogacy arrangement*. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a member, and any child born as a result of a *surrogacy arrangement*. This exclusion applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
    (a) Prenatal care;
    (b) Intrapartum care (or care provided during delivery and childbirth);
    (c) Postpartum care (or care for the *surrogate* following childbirth);
    (d) Mental Health Services related to the *surrogacy arrangement*;
    (e) Expenses relating to donor semen, including collection and preparation for implantation;
    (f) Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
    (g) Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
    (h) Preimplantation genetic diagnosis relating to a *surrogacy arrangement*;
    (i) Any complications of the child or *surrogate* resulting from the pregnancy; or
    (j) Any other health care services, supplies and medication relating to a *surrogacy arrangement*.
    Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except where the child is the adoptive child of insureds possessing an active *contract* with us and/ or the child possesses an active *contract* with us at the time of birth.
37. For any medicinal and recreational use of cannabis or marijuana.
38. Vehicle installations (modifications) which may include but are not limited to: adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.
39. For all health care services obtained at an urgent care *facility* that is a *non-network provider*.
40. Immunizations that are not medically necessary or medically indicated. This includes those used for travel and occupational.
41. For expenses, services, and *treatments* from a massage therapist to touch and manipulate the muscles and other soft tissues of the body.
42. For expenses, services, and *treatments* from a naprapathic specialist for conditions caused by contracted, injured, spasmed, bruised, and/or otherwise affected myofascial or connective tissue.
43. For expenses, services, and *treatments* from a naturopathic specialist for *treatment* of prevention, self-healing and use of natural therapies.
44. As a result of *injury* or *illness* arising out of, or in the course of, commission of a felony or engagement in an illegal occupation by a *member*.

TERMINATION

Termination of Contract

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract.*
2. The date of termination that the Health Insurance Marketplace provides us upon your request of cancellation to the Health Insurance Marketplace, or if you enrolled directly with us, the last day of the month we receive a request from you to terminate this contract, or any later date stated in your request will be effective the last day of the requested month but no further than 60 days in advance..
3. For a *covered eligible child* reaching the limiting age of 26, coverage under this *contract* will terminate at 11:59 p.m. on the last day of the year in which the *eligible child* 26.
4. The date we decline to renew this *contract*, as stated in the Discontinuance provision.
5. The date of your death, if you are the only *member* on this *contract.*
6. The date your eligibility for insurance under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract.*
7. The date your eligibility for coverage under this *contract* ceases as determined by the Health Insurance Marketplace.

If this *contract* is other than an individual coverage only plan (i.e. includes family coverage), it may be continued after your death:

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

This *contract* will be changed to a plan appropriate, as determined by us, to the *member(s)* that continue to be covered under it. Your *spouse* or youngest child will replace you as the primary *member*. A proper adjustment will be made in the premium required for this *contract* to be continued. We will also refund any premium paid and not earned due to your death. The refund will be based on the number of full months that remain to the next premium due date.

Refund upon Cancellation

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

Discontinuance

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

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

Portability of Coverage
If a person ceases to be a *member* due to the fact that the person no longer meets the definition of *dependent member* under the *contract*, the person will be eligible for continuation of coverage. If elected, we will continue the person's coverage under this *contract* by issuing an individual *contract*. The premium rate applicable to the new *contract* will be determined based on the *residence* of the person continuing coverage. All other terms and conditions of the new *contract*, as applicable to that person, will be the same as this *contract*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new *contract* to the extent satisfied under this *contract* at the time that the continuation of coverage is issued. (If the original coverage contains a family *deductible* which must be met by all *members* combined, only those expenses incurred by the *member* continuing coverage under the new *contract* will be applied toward the satisfaction of the *deductible amount* under the new *contract.*)

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

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

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. Notice given by or on behalf of you at 7711 Carondelet Ave., St. Louis, MO, 63105, or to any authorized agent of ours, with information sufficient to identify you, will be deemed notice to us.

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

Proof of Loss
Written *proof of loss* must be furnished to us in case of claim for *loss* for which this *contract* provides any periodic payment contingent upon continuing *loss* within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other *loss* within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. Subject to due written proof of loss, all accrued indemnities for *loss* for which this *contract* provides periodic payment will be paid monthly.

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, or
• You have an out-of-area emergency.

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

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

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

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

1. Sign, date and deliver to us *authorization*s to obtain any medical or other information, records or documents we deem relevant from any person or entity;
2. Obtain and furnish to us, or our representatives, any medical or other information, records or documents we deem relevant; and
3. 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 this *contract.*

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

Time for Payment of Claims
Benefits will be paid immediately upon receipt of *proof of loss*. Should we determine that additional supporting documentation is required to establish responsibility of payment, we shall pay benefits upon receipt of such additional supporting documentation.

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

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

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

If a proper claim is submitted by a public *hospital* or clinic, benefits payable will be paid to such *hospital* or clinic with or without an assignment from you or your *dependent*. Payment of benefits to the public *hospital* or clinic pursuant to this paragraph shall discharge us from all liability to you or your *dependent* to the extent of benefits paid.

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 Ambetter.homestatehealth.com.

The amount of reimbursement will be based on the following:

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

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

Assignment

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

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

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

Custodial Parent

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

Upon request by the custodial parent, we will:

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

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

Physical Examination

We 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. We, at our own expense, have the right and opportunity to make an autopsy of *member* 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 *contract* is not intended to, nor does it, create or grant any rights in favor of any *third party*, including but not limited to any *hospital,* provider or *medical practitioner* providing services to you*,* and this *contract* shall not be construed to create any *third party* beneficiary rights.

COMPLAINT AND APPEAL PROCESS

The following processes are available to address your problems and concerns. In addition, communicating a *complaint* or *appeal* will not affect your health care benefits or services and we will not treat you differently.

Call Member Services
We want to know your concerns so we can improve our services. Please contact our Member Services team at 1-855-650-3789 (TTY) 711 if you have questions or concerns. We will attempt to resolve your concern on your initial contact.

Complaint Process
You or your *authorized representative* may file a *complaint* by calling our Member Services Team at 1-855-650-3789 (TTY 711) or in writing by mailing or faxing your *grievance* to:

Ambetter from Home State Health
Attn: Grievance Department
7711 Carondelet Ave.
St. Louis, MO, 63105
Fax: 1-855-805-9812

If filing a written *complaint*, please include:

- Your first and last name
- Your *member* identification number
- Your address and telephone number
- Details surrounding your concern
- Any supporting documentation

Resolution Timeframe
Complaints will be promptly investigated. We will acknowledge your *complaint* by sending you a letter within ten business days of receipt of your *complaint*.

We will investigate your *complaint* within 20 business days after receipt of the *complaint*, unless the investigation cannot be completed within this time. If the investigation cannot be completed within 20 business days after receipt of the *complaint*, the enrollee shall be notified in writing on or before the 20th business day and the investigation shall be completed within 30 business days thereafter. The notice shall set forth with specificity the reasons for which additional time is needed for the investigation.

Urgent *complaints* are resolved as expeditiously as possible, no later than 72 hours after Home State Health receives the *complaint*.

Within five business days after the investigation is completed, someone not involved in the circumstances giving rise to the *complaint* or its investigation will decide upon the appropriate resolution of the *complaint* and notify you in writing of the health carrier's decision regarding the *complaint* and of the right to file an *appeal*. Within 15 business days after the investigation is completed, we will notify the person who submitted the *complaint* of the resolution of said *complaint*.

Appeal Process
You have up to 180 calendar days to file an *Appeal* from the date you receive the decision that you are requesting be overturned. You or your *Authorized Representative* may file an *appeal* in writing by mail or by fax at 1-855-805-9812. Please send your written *Appeal* to:

Ambetter from Home State Health
Attn: Appeals Department
7711 Carondelet Ave.
St. Louis, MO, 63105

When filing your *Appeal*, we ask that you provide a reason along with any information to support why your *Appeal* should be approved. If you would like to file your *Appeal* by telephone, you may call Member Services at 1-855-650-3789 (TTY 711).

Please include in your written *appeal* or be prepared to tell us the following:

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

Who Can File an Appeal
You have the right to have someone else help you with filing an *appeal*. This can be a relative, friend, lawyer, your doctor or health care provider, or other person. To have someone else file an *appeal* for you, we must have your written permission for that person to file an *appeal* on your behalf. You will need to obtain and fill out an Authorized Representative Form and return it to us so we will know who you have granted permission to represent you. The Authorized Representative Form can be obtained by calling Member Services at 1-855-650-3789 (TTY 711) or by visiting our website at ambetter.homestatehealth.com.

Rescission of coverage
If we rescind (withdraw) 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.

Resolution Timeframe
If you file an *Appeal*, an acknowledgement letter will be sent within ten business days from when the *Appeal* was received by Ambetter.

The *appeal* investigation will be completed and response provided within 20 business days after receipt of your *appeal* or within 30 calendar days, whichever is less. If additional time is needed and agreed upon by you, you will be notified in writing before the 20th business day with specific reasons why the additional time is needed and the additional time will be no greater than 14 calendar days. Within five business days after the investigation resolution someone not involved in the circumstances giving rise to the *appeal* or its investigation will decide upon the appropriate resolution of the *appeal* and notify the you in writing of our decision regarding the *appeal*.

Expedited Review
You or your authorized representative or provider acting on your behalf may request an expedited review when a non-expedited review would reasonably appear to seriously jeopardize the life or health of the *member* or jeopardize the *member's* ability to regain maximum function. A request for an expedited review may be submitted orally or in writing.

Upon receipt of request for an expedited review of a determination, we will notify you within 72 hours and written confirmation provided within three business days of the determination notice.

Access to Documents Relevant to the Appeal
You are entitled to receive, upon request and at no additional cost, reasonable access to and copies of all documents relevant to the *appeal* including any new or additional evidence. Relevant documents include documents and records relied upon in making the *appeal* decision and documents and records submitted in the course of making the *appeal* decision.

Request for External Review by an Independent Review Organization
If the Missouri Department of Commerce and Insurance is unable to resolve your *appeal* regarding the medical necessity, appropriateness, health care setting, level of care, or effectiveness of health care service, the Missouri Department of Commerce and Insurance may select an *Independent Review Organization (IRO)* to review your *appeal*.

For the purposes of the *appeals* process, an *Independent Review Organization (IRO)* means an entity that is accredited by a nationally recognized private accrediting organization to conduct independent external reviews of adverse benefit determinations and by the Missouri Department of Commerce and Insurance in accordance with Missouri law. The IRO is composed of persons who are not employed by Ambetter or any of its affiliates.

If the director of the DCI determines an *appeal* is unresolved after completion of DCI's consumer *complaint* process, DCI shall refer the unresolved *appeal* to an IRO. An unresolved *appeal* shall include a difference of opinion between a treating *physician* and the health carrier concerning the medical necessity, appropriateness, health care setting, level of care or effectiveness of a health care service.

The DCI will provide the IRO and upon request the member, *member's authorized* representative or health carrier copies of all medical records and any other relevant documents which the DCI has received from any party. The member, *member's authorized* representative and health carrier may review all the information submitted to the IRO for consideration.

The member, *member's authorized* representative or health carrier may also submit additional information to the DCI which the DCI shall forward to the IRO. All additional information must be received by the DCI. If a member, *member's authorized* representative or health carrier has information which contradicts information already provided the IRO, they should provide it as additional information. All additional information should be received by the DCI within 15 business days from the date the DCI mailed that party copies of the information provided to the IRO. An envelope's postmark shall determine the date of mailing. Information may be submitted to the DCI by means other than mail if it is in writing, typeset or easily transferred into typeset by the DCI's technology and a date of transmission is easily determined by the DCI. At the DCI's discretion, additional information which is received past the 15 working-day deadline may be submitted to the IRO.

The IRO shall request from the DCI any additional information it wants. The DCI shall gather the requested information from a *member*, *member's authorized* representative or health carrier or other appropriate entity and provide it to the IRO. If the DCI is unable to obtain the requested information, the IRO shall base its opinion on the information already provided.

Within 20 calendar days of receiving all material, the IRO shall submit to the DCI its opinion of the issues reviewed. Under exceptional circumstances, if the IRO requires additional time to complete its review, it should request in writing from the director an extension in the time to process the review, not to exceed five calendar days. Such a request should include the reasons for the request and a specific time at which the review is expected to be complete.

After the director receives the IRO's opinion, the director shall issue a decision which shall be binding upon the enrollee and the health carrier. The director's decision shall be in writing and must be provided to the enrollee and health carrier within 25 calendar days of receiving the IRO's opinion. In no event shall the time between the date the IRO receives the request for external review and the date the enrollee and the health carrier are notified of the director's decision be longer than 45 days.

An enrollee or enrollee's authorized representative or health carrier may request an expedited external review if the *adverse determination*:

(A) Concerns an admission, availability of care, continued stay, or health care service for which the enrollee received emergency services, but has not been discharged from a *facility*; or

(B) Involves a medical condition for which the delay occasioned by the standard external review time frame would jeopardize the life or health of the enrollee or jeopardize the enrollee's prognosis or ability to regain maximum function.

As expeditiously as possible after receipt of the request for expedited external review by the IRO, the IRO must issue its opinion as to whether the *adverse determination* should be upheld or reversed and submit its opinion to the director. As expeditiously as possible, but within no more than 72 hours after the receipt of the request for expedited external review by the IRO, the director shall issue notice to the enrollee and the health carrier of the director's determination and may issue a decision to uphold or reverse the *adverse determination*. If the notice is not in writing, the director must provide the written decision within 48 hours after the date of the notice of the determination.

If a request for external review of an *adverse determination* involves a denial of coverage based on a determination that the health care service or *treatment* recommended or requested is experimental or investigational, the following additional requirements must be met:

(A) The IRO shall make a preliminary determination as to whether the recommended or requested health care service or *treatment* that is the subject of the *adverse determination* is a covered service under the person's health benefit plan except for the health carrier's determination that the service or *treatment* is experimental or investigational for a particular medical condition; and is not explicitly listed as an excluded benefit under the enrollee's health benefit plan with the health carrier;

(B) The request for external review of an *adverse determination* involving a denial of coverage based on a health carrier's determination that the health care service or *treatment* recommended or requested is experimental or investigational must include a certification from the enrollee's *physician* that:

1. Standard health care services or *treatments* have not been effective in improving the condition of the enrollee; or
2. Standard health care services or *treatments* are not medically appropriate for the enrollee; or
3. There is no available standard health care service or *treatment* covered by the health carrier that is more beneficial than the recommended or requested health care service or *treatment*; and
4. The request for external review of an *adverse determination* involving the denial of coverage based on a determination that the requested *treatment* is experimental or investigational shall also include documentation

a) that the enrollee's treating *physician* has recommended a health care service or *treatment* that the *physician* certifies, in writing, is likely to be more beneficial to the enrollee, in the physician's opinion, than any available standard health care services or *treatments*; or

b) that the enrollee's treating physician, who is a licensed, board-certified, or board-eligible *physician* qualified to practice in the area of medicine appropriate to treat the enrollee's condition, has certified in writing that scientifically-valid studies using accepted protocols demonstrate that the health care service or *treatment* requested by the enrollee that is the subject of the *adverse determination* is likely to be more beneficial to the enrollee than any available standard health care services or *treatments*.

(C) When conducting such an external review, the IRO must select one or more clinical peers, who must be physicians or other *medical practitioners* who meet minimum qualifications and through clinical experience in the past three years are experts in the *treatment* of the enrollee's condition and knowledgeable about the recommended or requested health care service or *treatment*. Each clinical peer shall provide a written opinion to the assigned IRO on whether the recommended or requested health care service or *treatment* should be covered; and

(D) Each such clinical peer's opinion submitted to the IRO shall include the following information:

1. A description of the enrollee's medical condition;
2. A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or *treatment* is more likely than not to be beneficial to the enrollee than any available standard health care services or *treatments* and the adverse risks of the recommended or requested health care service or *treatment* would not be substantially increased over those of available standard health care services or *treatments*;
3. A description and analysis of any medical or scientific evidence considered in reaching the opinion;
4. Information on whether the reviewer's rationale for the opinion is based upon whether the recommended or requested health care service or *treatment* has been approved by the federal Food and Drug Administration for the condition, or whether medical or scientific evidence or evidence based standards demonstrate that the expected benefits of the recommended or requested health care service or *treatment* is more likely than not to be beneficial to the *member* than any available standard health care service or *treatment* and the adverse risks of the recommended or requested health care service or *treatment* would not substantially be increased over those of available standard health care services or *treatments*; and
5. A description and analysis of any evidence-based standard.

If we decide to reverse our *adverse determination* before or during the external review, we will notify you and the Missouri Department of Commerce and Insurance, within one business day of the decision.

If the IRO reverses our decision, we will immediately provide coverage for the health care service or services in question.

If the IRO and Missouri Department of Commerce and Insurance upholds our decision, you may have a right to file a lawsuit in any court having jurisdiction.

Filing a Complaint or Grievance with the Missouri Department of Commerce and Insurance,
You have the right to file a *complaint* or *grievance* with the Missouri Department of Commerce and Insurance (DCI) at any time. The Missouri Department of Commerce and Insurance may be contacted at the following address and telephone number:

Missouri Department of Commerce and Insurance
Attn: Division of Consumer Affairs
P.O. Box 690
Jefferson City, MO 65102
Phone: 1-800-726-7390

GENERAL PROVISIONS

Entire Contract
This *contract, the Schedule of Benefits, and* the enrollment application, including any riders or amendments attached, is the entire *contract* between you and us*.* No change in this *contract* will be valid unless it is approved by one of our officers and noted on or attached to this *contract.* No agent may:

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

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

We protect all oral, written and electronic PHI. We follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. We are required to notify you about these practices every year. This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. If you need more information or would like the complete notice, please visit https://ambetter.homestatehealth.com/privacy-practices.html or call Member Services at 1-855-650-3789 (TTY 711).

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

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

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 this *contract* that will not be considered a waiver of any rights under this *contract.* A past failure to strictly enforce this *contract* will not be a waiver of any rights in the future, even in the same situation or set of facts.

Rescissions
No misrepresentation of fact made regarding a *member* during the enrollment 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 enrollment application, including amendments, signed by a *member;*
2. A copy of the enrollment application, and any amendments, has been furnished to the *member(s),* or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to our determination to issue coverage to any *member.* A *member's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. "Rescind" has a retroactive effect and means the coverage was never in effect.

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

Time Limit on Certain Defenses
After two years from the date of issue of this *contract* no misstatements, except fraudulent misstatements, made by you in the enrollment application for your *contact* may be used to void your *contract* or to deny a claim for *loss* incurred commencing after the expiration of such two-year period. In accordance with the foregoing, we have the right to terminate this *contract* if you commit fraud or make a material misrepresentation during the enrollment application process, or we determined it appropriate to comply with law.

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

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 laws*.

Statement of Non-Discrimination

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

Ambetter from Home State Health:

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

If you need these services, contact Ambetter from Home State Health at 1-855-650-3789 (TTY 711).

If you believe that Ambetter from Home State Health 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: Grievance/Appeals Home State Health, 7711 Carondelet Ave., St. Louis, MO, 63105, 1-855-650-3789 (TTY 711), Fax 1-855-805-9812. You can file a *grievance* by mail, fax, or email. If you need help filing a *grievance*, Ambetter from Home State Health is available to help you. You can also file a civil rights *complaint* with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TTY).

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

Declaración de no discriminación

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

Ambetter de Home State Health:

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

Si necesita estos servicios, comuníquese con Ambetter de Home State Health a 1-855-650-3789 (TTY 711).

Si considera que Ambetter de Home State Health no le ha proporcionado estos servicios, o en cierto modo le ha discriminado debido a su raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja ante: Grievance/Appeals Home State Health, 7711 Carondelet Ave., St. Louis, MO, 63105, 1-855-650-3789 (TTY 711), Fax 1-855-805-9812. Usted puede presentar una queja por correo, fax, o correo electrónico. Si necesita ayuda para presentar una queja, Ambetter de Home State Health está disponible para brindarle ayuda. También puede presentar una queja de violación a sus derechos civiles ante la Oficina de derechos civiles del Departamento de Salud y Servicios Humanos de Estados Unidos (U.S. Department of Health and Human Services), en forma electrónica a través del portal de quejas de la Oficina de derechos civiles, disponible en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, o por correo o vía telefónica llamando al: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TTY).

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

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Home State Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Home State Health 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-855-650-3789 (TTY/TDD 1-877-250-6113)。
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Home State Health, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Serbo-Croatian:	Ako Vi, ili neko kome pomažete, imate pitanja u vezi Ambetter from Home State Health, imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-855-650-3789 (TTY/TDD 1-877-250-6113).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Home State Health hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-855-650-3789 (TTY/TDD 1-877-250-6113) an.
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Home State Health، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Home State Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-855-650-3789 (TTY/TDD 1-877-250-6113)로 전화하십시오.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Home State Health вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-855-650-3789 (TTY/TDD 1-877-250-6113).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Home State Health, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Tagalog:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from Home State Health 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 1-855-650-3789 (TTY/TDD 1-877-250-6113) पर कॉल करें।
Pennsylvania Dutch:	Vann du, adda ebbah's du am helfa bisht, ennichi questions hott veyyich Ambetter from Home State Health, dann hosht du's recht fa hilf greeya adda may aus finna diveyya in dei shprohch un's kosht nix. Fa shvetza mitt ebbah diveyya, kawl 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Persian:	اگر شما، یا کسي که به او کمک مي کنيد سؤالي در مورد Ambetter from Home State Health داريد، از اين حق برخورداريد که کمک و اطلاعات را بصورت رايگان به زبان خود دريافت کنيد. براي صحبت کردن با مترجم با شماره 1-855-650-3789 (TTY/TDD 1-877-250-6113) تماس بگيريد.
Cushite:	Yoo sii ykn namaa gargaaraa jirtuu wa'ee Ambetter from Home State Health irra gaaffi qabaatan ta'ee gargaarsaa fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana wajiin dubadhuu,1-855-650-3789 irra bilbilli (TTY/TDD 1-877-250-6113).
Portuguese:	Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from Home State Health, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Amharic:	እርስዎ ወይም እርሰዎ የሚረዱት ሰው ስለ Ambetter from Home State Health ጣብር ጥያቄ ካለዎት ያለምንም ወጪ በቋንቋዎ ድጋፍ እንዲሁም መረጃ የማግኘት መብት አለዎት፣ ፣ አስተርጓሚ ለማነጋገር በ 1-855-650-3789 (TTY/TDD 1-877-250-6113). ይደውሉ፣ ፣

AMB17-MO-C-00062