ambetter. FROM sunshine health
Insured by Celtic Insurance Company

2024 Evidence of Coverage

Ambetter Core

Ambetter.SunshineHealth.com

21663FL013-2024

Celtic Insurance Company
Ambetter from Sunshine Health
Ambetter Core

Home Office: 200 East Randolph, Ste. 3600 Chicago, IL 60601
Individual *Member* Contract

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 FLORIDA INSURANCE DEPARTMENT, THOSE CHANGES WILL BE INCORPORATED INTO YOUR HEALTH INSURANCE POLICY.

In this *contract,* the terms *"*you*,"* or *"*your*"* will refer to the *member* or any dependents enrolled in this *contract***.** The terms *"*we*," "*our*,"* or *"*us*"* will refer to Celtic Insurance Company or Ambetter from Sunshine Health.

AGREEMENT AND CONSIDERATION

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

Please read the copy of the application attached to this *contract*. Carefully check the application and write to the company at the address listed at the top of this page within 10 calendar days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. This application is a part of the *contract,* and the *contract* was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

GUARANTEED RENEWABLE

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

In addition to the above, this guarantee for continuity of coverage shall not prevent us from cancelling or non-renewing this *contract* in the following events:

1. non-payment of premium.
2. a *member* fails to pay any *deductible* or *copayment amount* in excess of $300 owed to us and not the provider of services within 90 calendar days after the date of the procedure.
3. a *member* is found to be in material breach of this *contract;* or
4. a change in federal or state law, no longer permits the continued offering of such coverage, such as CMS guidance related to individuals who are Medicare eligible. Rate changes are effective on a *member's* annual renewal date and will be based on each *member's* attained age, family structure, geographic region, tobacco usage and benefit plan at the time of renewal. We have the right to change premiums. We will notify the *member* in writing at least 45 calendar days prior to the renewal date of any change in premium rates. If we discontinue offering and decide not to renew all policies issued on

this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 180 calendar days prior to the date that we discontinue coverage.

At least 45 calendar days advanced written 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.

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

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 10 calendar days after you receive it. All premiums paid will be refunded, less any benefits paid, and the *contract* will be considered null and void from the *effective date*.

This *contract* contains a *deductible* provision.

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

Celtic Insurance Company

Kevin J. Counihan, President

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INTRODUCTION

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

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

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

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

Throughout this *contract* you will see references to Celtic Insurance Company and Ambetter from Sunshine Health. Ambetter from Sunshine Health operates under its legal entity, Celtic Insurance Company, and both may be referred to as the "plan."

How to Contact Us

Ambetter from Sunshine Health
P.O. Box 459089
Fort Lauderdale, FL 33345-9089

Normal Business Hours of Operation 8:00 a.m. to 8:00 p.m. local time.

Member Services	1-877-687-1169
Relay FL	1-800-955-8770
Fax	1-866-796-0523
Emergency	911
24/7 Nurse Advice Line	1-877-687-1169

Interpreter Services

Ambetter from Sunshine Health has a free service to help our *members* who speak languages other than English. These services ensure that you and your *provider* can talk about your medical or *behavioral health* concerns in a way that is most comfortable for you. Our interpreter services are provided at no cost to you. We have representatives that speak Spanish and medical interpreters to assist with other languages. *Members* who are blind or visually impaired and need help with interpretation can call *Member* Services for an oral interpretation.

To arrange for interpretation services, please call *Member* Services.

MEMBER RIGHTS AND RESPONSIBILITES

We are committed to:

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

If you have difficulty locating a *PCP*, *specialist physician, hospital* or other *network provider* please contact us so we can assist you with accessing or locating a provider who contracts with us. *Physicians* 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-network hospital*s. Your Ambetter coverage requires you to use *network providers* with limited exceptions.

You have the right to:

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

10. See your medical records.
11. Be kept informed of *covered* and non-covered *services*, program changes, how to access services, *PCP* assignment, providers, advance directive information, referrals and *authorizations*, benefit denials, *member* rights and responsibilities, and our other rules and guidelines. We will notify you at least 60 calendar days before the *effective date* of the modifications. Such notices shall include:
    a. Any changes in clinical review criteria; or
    b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
12. A current list of *network providers*. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
13. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, ethnicity, race, religion, gender, sexual orientation, national origin, physical or mental disability, or expected health or genetic status. Access *medically necessary* urgent and *emergency* services 24 hours a day, seven days a week.
14. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.
15. Refuse treatment to the extent the law allows without jeopardizing future treatment and be informed by your *provider*(s) of the medical consequences.
16. 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 plan that may help you. You will make the final decision.
17. Select your *PCP* within the *network*. You also have the right to change your *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 *provider* is your *PCP*.
19. An interpreter when you do not speak or understand the language of the area.
20. A second opinion by a *network* provider, if you want more information about your treatment or would like to explore additional treatment options.
21. Make advance directives for healthcare decisions. This includes planning treatment before you need it.
22. Determine what actions should be taken regarding your health if you are no longer able to make decisions for yourself because of *illness* or because you are incapacitated. You have the right to have your wishes known by completing Advance directives forms. Advance directives are forms you can complete to protect your rights for medical care. It can help your *PCP* and other providers understand your wishes about your health. Advance directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself. Examples of advance directives include:
    a. Living Will.
    b. Health Care Power of Attorney; and
    c. "Do Not Resuscitate" Orders. *Members* also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this entire *contract*.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*,

hospitalizations, medications, and other matters about your health that we or your *medical practitioners* need in order to provide care.

4. You should make it known whether you clearly understand your care and what is expected of you.
5. You need to ask questions of your *provider* until you understand the care you are receiving.
6. Review and understand the information you receive about your *Ambetter plan*. You need to know the proper use of *covered services*.
7. Show your *member* identification card and keep scheduled appointments with your *provider* and call the *provider*'s office during office hours whenever possible if you have a delay or cancellation.
8. Know the name of your assigned *primary care physician*. You should establish a relationship with your *provider*.
9. You may change your *PCP* verbally or in writing by contacting our *Member* Services.
10. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
11. Follow the treatment plans and instructions for care that you have agreed on with your health care professionals and *provider*.
12. Tell your health care professional and *provider* if you do not understand your treatment plan or what is expected of you. You should work with your *PCP* to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.
13. Follow all health benefit plan guidelines, provisions, policies and procedures.
14. Use any *emergency* room only when you think you have a medical *emergency*. For all other care, you should call your *PCP*.
15. When you enroll in this coverage, give all information about any other medical coverage you have. If, at any time, you get other medical coverage besides this coverage, you must tell the entity through which you enrolled (Marketplace or Ambetter).
16. Pay your monthly premiums on time and pay all *deductible amounts, copayment amounts*, or *coinsurance amount* at the time of service.
17. Inform the entity through which you enrolled for this *contract* if you have any changes in your name, address, or family *members* covered under this *contract* within 60 calendar days from the date of the event. These changes can also be done by logging into your consumer dashboard on member.ambetterhealth.com
18. Notify us or the entity you enrolled with of any enrollment related changes that would affect your *contract*, such as: birth of a child, or adoption, marriage, divorce, adding/removing a dependent, *spouse*/domestic partner becomes eligible under a different insurer, enrollment changes, address changes, or incarceration where *member* cost share would need to transfer from one policy to another policy.

IMPORTANT INFORMATION

Provider Directory

A listing of *network providers* is available online at Ambetter.SunshineHealth.com. We have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide you with your healthcare services. You may find any of our *network providers* by completing the "Find a Doctor" function on our website and selecting Ambetter from Sunshine Health. There you will have the ability to narrow your search by provider specialty, zip code, gender, languages spoken and whether or not they are currently accepting new patients. Your search will produce a list of providers based on your search criteria and will give you other information such as address, phone number, office hours, specialty and board certifications and qualifications.

At any time, you can request a copy of the provider directory at no charge by calling *Member* Services. In order to obtain benefits, you may be required to designate a *PCP* for each *member.* We can help you choose a *PCP*. We can make your choice of *PCP* effective on the next business day.

Call the *PCP*'s office if you want to make an appointment. If you need help, call *Member* Services. We will help you make the appointment.

You may also contact us at Member Services to request information about whether a physician, hospital, or other medical practitioner is a network provider. We will respond to any such requests within one business day.

If you receive services from a non-network provider because of inaccurate information in the Provider Directory or in response to an inquiry about network status, please contact Member Services. If the services you received are otherwise covered services, you will only be responsible for paying the cost sharing that applies to network providers and will not be balance billed by the non-network provider.

Member Identification Card

We will mail you a *member* identification card after we receive your completed enrollment materials and you have paid your initial binder payment. This card is proof that you are enrolled in the Ambetter by Sunshine Health plan. You need to keep this card with you at all times. Please show this card every time you go for any service under the *contract*. The *Member* identification card will show your name, *member* identification number and *copayment amounts* required at the time of service. If you do not get your *member* identification card within a few weeks after you enroll, please call *Member* Services. We will send you another card. A temporary identification card can be downloaded from Ambetter.SunshineHealth.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.SunshineHealth.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 Prescription Drug List
8. *Deductible* and *copayment* accumulators.
9. Selecting a *PCP*.
10. Health Risk Assessment form, “Welcome Survey.”

Quality Improvement

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

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

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

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

Protection from Balance Billing

Under federal law, effective January 1, 2022, non-network providers or facilities are prohibited from balance billing health plan members for services that are subject to balance billing protections as described in the Definitions section of this contract. You will only be responsible for paying your member cost share for these services, which is calculated as if you had received the services from a network provider and based on the recognized amount as defined in applicable law.

DEFINITIONS

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

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

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

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

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

1. A denial of a request for service.
2. A denial, reduction or failure to provide or make payment in whole or in part for a covered service.
3. A determination that an admission, continued stay, or other health care service does not meet our requirements for *medical necessity*, appropriateness, health care setting, or level of care or effectiveness.
4. A determination that a service is *experimental, investigational, cosmetic treatment,* not *medically necessary* or inappropriate.
5. A denial of coverage based upon an eligibility determination.
6. A determination that *balance billing protections* do not apply to a service.
7. An incorrectly calculated amount of cost sharing a member owes when *balance billing protections* apply.
8. A rescission of coverage determination as described in the General Provisions section of this policy.
9. A prospective review or retrospective review determination that denies, reduces or fails to provide or make payment, in whole or in part, for a covered service.

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

Allowed amount (also see *Eligible Expense*) is the maximum amount we will pay a *Provider* for a *Covered Service.* when a *Covered Service* is received from a *Network Provider*, the *Allowed Amount* is the amount the *Provider* agreed to accept from us as payment for that particular service. In all cases, the *Allowed Amount* will be subject to *Cost Sharing* (e.g., *Deductible*, *Coinsurance* and *Copayment*) per the *Member's* benefits. This amount excludes any payments made to the *Provider* by us as a result of Federal or State Arbitration.

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 a*llowed amount* that we pay. However, you will not be responsible for *balance billing* for non-network care that is subject to *balance billing protections* and otherwise covered under your *contract* See Balance billing, *Balance billing protections*, and *non-network provider* definitions for additional information. If you are balanced billed in these situations, please contact Member Services immediately at the number listed on the back of your member identification card.

Ambetter-designated Telehealth Provider means the vendor selected by Ambetter to contract with providers to render telehealth services, including Virtual 24/7 Care benefits, to members. All services provided through the Ambetter-designated telehealth provider shall be deemed independent from Ambetter to ensure that a member's care and treatment plan are rendered via a practicing physician, or other medical professional with appropriate licensure.

Appeal means a *grievance* that is related to a denial of services or a claim in whole or part, is called an *appeal*. An *appeal* deals specifically with denial, reduction, termination, and/or suspension of the medical necessity for a service or treatment that is a benefit or for the denial of a claim for services.

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

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

Attending physician means the *physician* responsible for the care of a patient or the *physician* supervising the care of patients by residents, or medical students.

Autism spectrum disorder (ASD) 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.

Authorization or ***Authorized*** (also *"Prior Authorization"* or "Approval") means our decision to approve the medical necessity or the appropriateness of a health care service, device, or drug for an enrollee by the enrollee's *PCP* or provider group. "*Prior authorization*" includes prospective, or *utilization review* procedures conducted prior to providing a health care service, device, or drug.

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

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

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

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

Balance billing protections means the protections against *balance billing* under the federal No Surprises Act. These protections apply to covered services that are:

1. Emergency services provided to a member, as well as services provided after the member is stabilized unless the member gave notice and consent to be balance billed for the post-stabilization services.
2. Non-emergency health care services provided to a member at a network hospital or at a network ambulatory surgical center unless if member gave notice and consent pursuant to the federal No Surprises Act to be balance billed by the non-network provider; or
3. Air ambulance services provided to a member by a non-network provider.

You will only be responsible for paying your member cost share for these services, which is calculated as if you had received the services from a network provider and is based on the recognized amount as defined in applicable law. If you are balance billed for any of the above services, contact Member Services immediately at the number listed on the back of your member identification card.

Behavioral health is a state of an individual's well-being. It is a continuum of prevention, intervention, treatment and recovery support services for mental health and substance use. *services*

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

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

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

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of medically necessary transplants or other medical services 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.

Child Health Supervision Services means *physician*-delivered or *physician*-supervised services that include the services described in the Major Medical Expense section of this *contract.* These services do not include *hospital* charges.

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

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

Complaint means any expression of dissatisfaction by you, including dissatisfaction with the administration, claims practices or provision of services, which relates to the quality of care provided by a *provider* pursuant to our *contract* and which is submitted to us or to a state agency. A *complaint* is part of the informal steps of a *grievance* procedure and is not part of the formal steps of a *grievance* procedure unless it is a *grievance* as defined in this section. Examples include but not limited:

1. Care received from a provider.
2. Service received from a provider.
3. How long it takes to get an appointment.
4. How you were treated
5. Service that is not included as an Ambetter from Sunshine Health benefit.
6. How a bill was paid
7. How you were treated by Ambetter from Sunshine Health staff.

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from *pregnancy* but are adversely affected by *pregnancy* or are caused by *pregnancy* and not, from a medical viewpoint, associated with a normal *pregnancy*. This includes ectopic *pregnancy*, spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity; but it does not include false labor, preeclampsia, edema, prolonged labor, *physician* prescribed rest during the period of *pregnancy*, morning sickness, and conditions of comparable severity associated with management of a difficult *pregnancy*, and not constituting a medically classifiable distinct complication of *pregnancy*.
2. An *emergency* cesarean section where there is immediate concern for the health or the mother and/or baby, or a non-elective cesarean section.

Continuing care patient means an individual who, with respect to a provider or facility, is (i) undergoing a treatment for a *serious and complex condition* from that provider or facility; (ii) is undergoing a course of institutional or *inpatient* care from that provider or facility; (iii) is scheduled to

undergo non-elective *surgery* from that provider, including postoperative care; (iv) is pregnant and undergoing a course of treatment for the *pregnancy*; or (v) is or was 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, including your *Schedule of Benefits* and any amendments.

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

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

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

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

Cost sharing reductions help reduce the amount you have to pay in *deductible* s, 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 Alaska Native may qualify for additional *cost sharing reductions*.

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

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

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

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

1. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet.
2. Preparation and administration of special diets.
3. Supervision of the administration of medication by a caregiver.
4. Supervision of self-administration of medication; or

5. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, educational care or recreational care.

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

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

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

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

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

Drug discount, coupon or ***copayment card or manufacturer supplied prepaid credit card*** means cards or coupons typically provided by a drug manufacturer. The card/coupons discount the *copay* or your other out-of-pocket costs (e.g., *deductible* or *maximum out-of-pocket amount*) to acquire a medication.

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

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

Eligible child means the child of a *covered person*, 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 for whom legal guardianship has been awarded to you, your *spouse* or domestic partner. It is your responsibility to notify the entity through which you enrolled (either the Health Insurance Marketplace or us) if your child ceases to be an *eligible child*. You must reimburse us for any benefits that we provide or pay for a child at a time when the child did not qualify as an *eligible child*.
5. A child from the first of the month following the month in which the child turns age twenty-six (26) until the end of the calendar year in which the child turns thirty (30) years of age; and who is a resident of Florida or a full-time or part-time student; and is not provided coverage as a

named *member* under any other group or individual health benefit plan; or is not entitled to benefits under Title XVIII of the Social Security Act.

If a dependent child is provided coverage under the *contract* after the child reaches age 26 and the coverage for the child is subsequently terminated prior to the end of the calendar year in which the child turns age thirty (30), the child is ineligible to be covered again under the *contract* unless the child was continuously covered by other creditable coverage without a coverage gap of more than 63 calendar days.

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

1. For *network providers*: When a *covered service* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.
2. For *non-network providers,* unless otherwise required by Federal or Florida law, the *eligible expense* is as follows:
    a. When *balance billing protections* apply to covered *emergency services and care* that are received from a *non-network provider* that is a hospital, ambulatory surgery center, or urgent care center, the *eligible expense* is the lesser of: (1) the *provider's* charges; (2) the usual and customary provider charges for similar services in the community where the services were provided; or (3) the charge mutually agreed to by the health maintenance organization and the *provider* within 60 days of the submittal of the claim.. When a covered *emergency service* is received from a *non-network provider* outside of Florida, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full. If the provider has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by applicable law, the eligible service expense is reimbursement as determined by us and as required by applicable law. You should not be balance billed for the difference between the amount we pay and the provider's charges, but you may be subject to cost-sharing obligations. 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 *post-stabilization service* is received from a *non-network provider*, the *eligible expense* is reimbursement as determined by us and as required by applicable law. Unless there is *notice and consent* to waive *balance billing protections*, 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.
    c. When a *covered service* is received from a *non-network* professional provider who renders non-*emergency services* at a *network* facility, the *eligible expense* is the lesser of: (1) the provider's billed charges, (2) the *usual and customary* provider charges for similar services in the community where the services were provided, or (3) the charge mutually agreed to by us and the provider within 60 days of the submittal of the claim. Unless you had the ability and opportunity to choose a participating provider and there is *notice and consent* to waive *balance billing protections*, you will not be balance billed for the difference between the amount we pay and the provider's charges, but you may be subject to cost-sharing obligations. If you are balance billed in these situations, please contact *Member* Services immediately at the number listed on the back of your *member* identification card.

d. For all other *covered service*s received from a *non-network provider* for which any needed authorization is received by us, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the *non-network provider* as payment in full (you will not be billed for the difference between the negotiated fee and the provider's charge). If there is no negotiated fee agreed to by the *non-network provider* with us, the *eligible expense* is reimbursement as determined by us and as required by *applicable law*. In addition to applicable cost-sharing, you may be balance billed for these services.

Emergency condition means a medical condition or a *behavioral health* condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

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

Emergency services means covered services needed to evaluate and stabilize an emergency condition. This includes a medical screening examination in a hospital emergency department or independent freestanding emergency department to evaluate the emergency condition, as well as services needed to stabilize the emergency condition. Services to stabilize an emergency condition can be provided in any department of a hospital.

Follow-up care is not considered emergency care. Benefits are provided for emergency services without prior authorization. Benefits for emergency services include facility costs and physician services and supplies and prescription drugs charged by that facility. If you are admitted to a hospital as a result of an emergency condition, you must notify us or verify that your physician has notified us of your admission within 48 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the inpatient setting is appropriate, and if appropriate, the number of days considered medically necessary. By contacting us, you may avoid financial responsibility for any inpatient care that is determined to be not medically necessary under your contract. If your provider does not contract with us, you may be financially responsible for any care we determine is not a covered service because it is not medically necessary. Care and treatment provided once you are stabilized is no longer considered emergency services under your *contract*. Continuation of care beyond what is needed to evaluate or stabilize your condition in an emergency will not be a covered service unless we authorize the continuation of care, and it is medically necessary.

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

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

1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the claimant or the ability of the claimant to regain maximum function.

2. In the opinion of a *physician* with knowledge of the claimant's medical condition, the claimant is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*.
3. A *physician* with knowledge of the claimant's medical condition determines that the *grievance* shall be treated as an *expedited appeal*.

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

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("FDA") regulation, regardless of whether the trial is subject to FDA oversight.
2. An *unproven service.*
3. Subject to FDA approval, and:
   a. It does not have FDA approval.
   b. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
   c. It has FDA approval but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of an FDA-approved drug is a use that is determined by us to be:
      i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services.
      ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
      iii. Not an *unproven service*.
   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 I, II, 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*, *skilled nursing facility* or *rehabilitation facility* by the state in which it operates.
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *physician* and the direct supervision of a registered nurse.
3. Maintains a daily record on each patient.
4. Has an effective *utilization review* plan.
5. Provides each patient with a planned program of observation prescribed by a *physician;* and
6. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing *generally accepted standards of medical practice* for that condition.

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

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

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

1. Availability, coverage for the 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 a *subscriber* and us.

A *grievance* does not include a written *complaint* submitted by or on behalf of a *member* eligible for a *grievance* and *appeals* procedure provided by us pursuant to *contract* with the Federal Government under Title XVIII of the Social Security Act.

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

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

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

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

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

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

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

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

Hospice means services designed for and provided to members who are diagnosed with a terminal condition and are in a hospice inpatient program or in a home setting, as certified by a network physician.

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 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 to short term observation status, a *member* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

This includes services of an osteopathic *hospital* when services are available in the *service area.*

Individual coverage health reimbursement arrangement (ICHRA) means type of health reimbursement arrangement in which employers of any size can reimburse employees for some or all of the premiums that the employees pay for health insurance that they purchase on their own.

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 any *member*, or any person residing with a *member*.

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

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

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

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

Long-term acute care *means services that specialize in treating critically ill patients, including those dependent on ventilators for life support, patients with complex wounds and patients with multiple organ system failure who require extended treatment in hospital settings.*

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

Loss of minimum essential coverage means in the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of *loss* of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). *Loss* of eligibility does not include a *loss* due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). *Loss* of eligibility for coverage includes, but is not limited to:

1. *Loss* of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any *loss* of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a *service area*, *loss* of coverage because an individual no longer resides, lives, or works in the *service area* (whether or not within the choice of the individual);
3. In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a *service area*, *loss* of coverage because an individual no longer resides, lives, or works in the *service area* (whether or not within the choice of the individual), and no other benefit package is available to the individual;
4. A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits.
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in 26 CFR § 54.9802-1(d)) that includes the individual.
6. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent; and
7. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

Managed drug limitations means limits in coverage based upon time period, amount or dose of a drug, quantity limits, age or gender limitations, requirements for previously tried and failed drugs or other specified predetermined criteria.

Maximum out-of-pocket amount means the maximum amount a member must pay towards covered services in the form of cost sharing in a given plan year. A member's deductible amount, prescription drug deductible amount (if applicable), copayment amounts, and coinsurance amounts all contribute towards the maximum out-of-pocket amount. The individual and family maximum out-of-pocket amounts are shown in your Schedule of Benefits.

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

Medical practitioner includes but is not limited to the *physicians,* physician's assistants, nurses, nurse clinicians, nurse practitioners, pharmacists, marriage and family therapists, clinical social workers, mental health counselors, speech-language pathologists, audiologists, occupational therapists, respiratory therapists, physical therapists, ambulance services, *hospital*s, skilled nursing facilities, or other health care providers properly licensed in the State of Florida.

Medically necessary means our decision as to whether any medical service, 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 medical practice standards.
3. Is not *custodial care*.
4. Is not solely for the convenience of the *physician* or the *member*.
5. Is not *experimental* or investigational.
6. Is provided in the most cost-effective care facility or setting.
7. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; and
8. When specifically applied to a *hospital* confinement, it means that the diagnosis and treatment of your medical symptoms or conditions cannot be safely provided as an outpatient.

Charges incurred for treatment not *medically necessary* are not *eligible expense*s.

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

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

Minimum essential coverage means 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.

Necessary medical supplies means medical supplies that are:

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

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

Network means a group of Providers or Facilities (including, but not limited to *Hospitals*, *Inpatient* mental 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 healthcare services to our *Members* for an agreed upon fee. *Members* will receive most if not all of their healthcare services by accessing the *Network*.

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

Network provider(s) means any person or entity that has entered into a *contract* with Ambetter from {insert health plan} to provide *covered services* to *members* enrolled under this *Contract* including but not limited to, *hospitals*, specialty *hospitals*, Urgent Care facilities, *physician*s, pharmacies, laboratories and other health professionals within our *service area*.

Non-network provider means a medical practitioner, provider facility or other provider who is NOT a network provider. Services received from a non-network provider are not covered, except for:

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

Notice and consent means the conditions that must be met in order for a member to waive *balance billing protections* as permitted by the federal No Surprises Act. Notice and consent occurs only when each of the following conditions is met:

1. The non-network provider provides the member a written notice in the format required by applicable law that states the provider is a non-network provider, includes a good-faith estimate of the non-network provider's charges for the services, identifies any prior authorization or other limitations that may be required in advance of receiving the services, and clearly states that consent is optional and the member may seek care from a network provider.

2. The non-network provider provides the notice described above to the member at least 72 hours before the services are furnished, except that for services scheduled within 72 hours, the notice must be provided at least three hours before the services are furnished.
3. The member provides written consent to be treated by the non-network provider that includes the following:
    a. The member's acknowledgement that they have been provided written notice as described above and informed that payment of the non-network provider's *billed amount* may not accrue toward the member's deductible or maximum out-of-pocket amount.
    b. The member's statement that by signing the consent, they agree to be treated by the non-network provider and understand they may be balance billed and subject to cost-sharing that applies to non-network providers; and
    c. The time and date on which the member received the written notice and signed the consent to receive services from the non-network provider.
4. The member's consent is provided voluntarily, obtained by the non-network provider in the format required by applicable law, and not revoked by the member before the services are provided.
5. The non-network provider provides the member the notice document and the consent document together, but physically separate from other documents.
6. The non-network provider provides the member a copy of the signed written notice and consent through email or mail.

Notice and consent will not waive *balance billing protections* for emergency services, air ambulance services, services furnished due to unforeseen and urgent medical needs, services provided by a non-network provider when there is no network provider available at the facility or ancillary services (which are services related to emergency medicine, anesthesiology, pathology, radiology and neonatology; diagnostic services such as radiology and laboratory services; and services provided by non-physician practitioners, assistant surgeons, hospitalists, and intensivists). Notice and consent will waive *balance billing protections* for post-stabilization services only if all the following additional conditions are met:

1. The attending emergency physician or treating provider determines the member is able to travel using nonmedical transportation or nonemergency medical transportation to an available network provider or facility located within a reasonable travel distance, taking into consideration the member's medical condition.
2. The member (or the member's authorized representative) is in a condition to provide notice and consent as determined by the *attending physician* or treating provider using appropriate medical judgment.
3. The non-network provider satisfies any additional requirements or prohibitions as may be imposed under applicable state law.

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, workers compensation policy, 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.

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

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

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

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

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

Post-stabilization services means services furnished after a member's emergency condition is stabilized and as part of outpatient observation or inpatient or outpatient services with respect to the visit in which other emergency services are furnished.

Pre-service claim means any claim for benefits for medical care or treatment that has not yet been provided and requires the approval of the plan in advance of the *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 expenses*, shown in your *Schedule of Benefits*, if applicable, that must actually be paid during any calendar year before any *prescription drug* benefits are payable. The family *prescription drug deductible amount* is two times the individual *prescription drug deductible amount*. For family coverage, once a *covered person* has met the individual *prescription drug deductible amount*, any remaining family *prescription drug deductible amount* can be met with the combination of any one or more *covered person*s' *eligible expenses*.

Primary care physician (PCP) means *a* provider who gives or directs health care services for you. *PCPs* include internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), *Physician* Assistants (PA), obstetrician gynecologist (ob-gyn) and pediatricians or any other practice allowed by 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 decision to approve specialty or other *medically necessary* care for a *member* by the *member's primary care physician* or provider group prior to receiving services.

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

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

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

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

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

Qualified Small Employer Health Reimbursement Arrangement allows small employers who don't offer group health insurance benefits to reimburse employees – tax-free – for some or all of the premiums they pay for coverage purchased in the individual market, on or off-exchange. The *QSEHRA* can also be used to reimburse employees for out-of-pocket medical expenses.

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

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

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

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

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

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

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

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

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

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

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

Service area means a geographical area, made up of counties, where we have been authorized by the State of Florida 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 *Member* Services.

Skilled nursing facility means services that include *physician* services, room and board limited to semi-private rooms, unless a private room is *medically necessary* or a semi-private room is not available, and patient meals, general nursing care, rehabilitative services, drugs (drugs and biologicals), medical supplies and the use of appliances and equipment furnished by *skilled nursing facility*. Limitations apply, see your *Schedule of Benefits*.

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

Spouse means the person to whom you are lawfully married.

Stabilize means, with respect to a member who has not experienced an emergency condition, that the member is no longer experiencing further deterioration as a result of a prior illness or injury and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*. Stabilize, with respect to a member who has experienced an emergency 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* of the member to another facility or discharge of the member (*See Ambulance Services Benefits provision under the Major Medical Expense Benefit section).

Step-therapy protocol means a written protocol that specifies the order in which certain *prescription drugs*, medical procedures, or courses of treatment must be used to treat a member's condition.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Urgent grievance means a *grievance* involving a situation that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.

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.
2. As a result of an unforeseen *illness, injury,* or the onset of acute or severe symptoms.

Usual and customary means the fair market value of the service provided (i.e., what a willing buyer will pay, and a willing seller will accept in an arm's-length transaction). In determining the fair market value of the service provided, we consider, among other things, the amounts reasonably accepted by providers, when available, for the service or similar services in the geographical area in which the service was received.

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

Virtual 24/7 Care means a telehealth services benefit for virtual urgent care and virtual behavioral health provided to members through the Ambetter-designated telehealth provider. These services can be accessed through the Ambetter-designated telehealth provider's website.

DEPENDENT MEMBER COVERAGE

Dependent Member Eligibility

Your *dependent members* become eligible for coverage under this *contract* on the latter of:

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

Effective Date for Initial Dependent Members

Dependents included in the initial enrollment application for this *contract* will be covered on your *effective date*.

Coverage for a Newborn Child

An *eligible child* born to you, or your covered family member(s) 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 your *Schedule of Benefits*.

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

Coverage for an Adopted Child

Coverage for children under this *contract* will be provided for the adopted child of a *member* who has family coverage. Coverage is provided from the moment of placement to a child the *member* proposes to adopt who is placed in the *member's residence* in compliance with Chapter 63, Florida Statues. A newborn infant who is adopted by the *member* is covered from the moment of birth if a written agreement to adopt such child has been entered into prior to the birth of the child, whether or not such agreement is enforceable. However, coverage will not be provided in the event the child is not ultimately placed in the *member's residence* in compliance with chapter 63, Florida Statutes.

The *member's* adopted child is covered from the moment of placement in the *residence*, or if a newborn, from the moment of birth, if the child is enrolled timely as specified in the Special and Limited Enrollment Period provision.

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child and we have received notification from the 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 Marketplace within 60 days of the birth or placement and b) any additional premium required for the addition of the child within 90 days of the date of *placement.*
As used in this provision, *"placement"* means the earlier of:

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

Adding Other Dependent Members

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

ONGOING ELIGIBILITY

For All Members

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

1. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *contract* or the date that we have not received timely premium payments in accordance with the terms of this *contract*; or
2. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or
3. The date of termination that the Marketplace provides us upon your request of cancellation to the Marketplace, or if you enrolled directly with us, the date we receive a request from you to terminate this *contract*, or any later date stated in your request; or
4. The date we decline to renew this *contract,* as stated in the Discontinuance provision; or
5. The date of *a member's* death.
6. The *subscriber* residing outside the *service area* or moving permanently outside the *service area* of this plan.

If you have material modifications (examples include a change in life event such as marriage, death or other change in family status), or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596 or you can access your Ambetter *member* portal to process these changes. You can access your consumer dashboard at member.ambetterhealth.com to process these changes. If you enrolled through Ambetter contact *Member* Services.

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 a dependent *member* reaching the limiting age of 30, coverage under this *contract* will terminate the thirty-first (31st) of December the year that the dependent *member* turns 30 years of age.

We must receive notification within 90 calendar days of the date a *dependent member* ceases to be an eligible *dependent member*. If we receive notice more than 90 calendar days from this date, any unearned premium will be credited only from the first day of the *contract*/calendar month in which we receive the notice. If you 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's *effective date* of coverage and *member* identification card.

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

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

If health benefits are denied for the stated reason that the child has reached the limiting age for dependent coverage specified in this *contract*, the *member* has the burden of establishing that the child continues to meet the criteria specified above. Failure to provide the required proof may result in the dependent's termination of coverage.

The coverage of the child may be continued, but not beyond the termination date of such incapacity or such dependence. This provision shall in no event limit the application of any other *contract* provisions terminating such child's coverage for any other reason than the attainment of the limiting age. Whether you are enrolled through the Health Insurance Marketplace and you have material modifications (examples include a change in life event such as marriage, death or other change in family status) you can access your consumer dashboard at member.ambetterhealth.com to process these changes.

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.

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 2 calendar days of your *effective date* so we can review and authorize *medically necessary* services. If services are at a *non-network hospital*, claims will be paid at the Ambetter allowable until you are discharged or no longer eligible for benefits and you may be billed for any balance of costs above the Ambetter allowable.

Out of Service area Dependent Member Coverage

A *dependent member's* coverage will not cease should the *dependent member* live outside the *service area* if a court order requires the *member* to cover such *dependent member*.

Open Enrollment

There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 1, 2023, and extends through January 15, 2024. *Qualified individuals* who enroll on or before December 15, 2023, will have an *effective date* of coverage on January 1, 2024.

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

1. The *qualified individual* has not been determined eligible for *advance premium tax credits* or *cost-sharing reductions*; or
2. The *qualified individual* pays the entire premium for the first partial month of coverage as well as all *cost sharing*, thereby waiving the benefit of *advanced premium tax credit* and *cost-sharing reduction* payments until the first of the next month. We will send written annual open enrollment notification to each *member* no earlier than the first of September, and no later than the thirtieth of September.

Special and Limited Enrollment

In general, a *qualified individual* has 60 calendar days to report certain life changes, known as "qualifying events," to the Health Insurance Marketplace or by using Ambetter's *Enhanced Direct Enrollment* tool. If a qualified individual loses Medicaid or CHIP coverage that is considered minimum essential coverage, they have up to 90 days after the loss of minimum essential coverage to enroll in a Marketplace plan. *Qualified Individual*s may be granted a Special Enrollment Period where they

may enroll in or change to a different Marketplace plan during the current year if they have a qualifying event. Qualifying events include:

1. A *qualified individual* or *dependent* experiences a *loss of minimum essential coverage*, non-calendar year group or individual health insurance coverage, *pregnancy*-related coverage, access to healthcare 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 calendar 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 *advanced premium tax credits* or has a change in *eligibility* for *cost-sharing reductions*.
8. A *qualified individual* or *dependent* who is enrolled in an eligible employer-sponsored plan is determined newly eligible for *advanced premium tax credits* based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-2(c)(3).
9. A *qualified individual*, enrollee, or *dependent* gains access to new QHPs as a result of a permanent move, and had *minimum essential coverage* as described in 26 CFR 1.5000A–1(b) for one or more days during the 60 calendar 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 calendar 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 Health and Human Services (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 Sunshine Health, please contact *Member* Services 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* experiences a *loss of minimum essential coverage*, coverage is effective on the first day of the following month.

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

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

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

If a *qualified individual*, enrollee, or *dependent* did not receive timely notice of an event that triggers eligibility for a special enrollment period, and otherwise was reasonably unaware that a qualifying event occurred, the Health Insurance Marketplace must allow the *qualified individual*, enrollee, or *dependent* to select a new plan within 60 calendar 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.

PREMIUMS

Premium Payment

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

Grace Period

When a *member* is receiving a premium subsidy:
After the first premium is paid, a grace period of three months 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 *advanced 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 *advanced premium tax credits* on behalf of the *member* from the Department of the Treasury and will return the *advanced premium tax credits* on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above. A *member* is not eligible to re-enroll once terminated, unless a *member* has a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

When a *member* is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 30-day grace period. If your payment is not received by day 30, your account will move into suspend status. Please ensure your payment is posted at least 10 days prior to due date to ensure timely processing and payment posting. 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. We will notify Health and Human Services (HHS), as necessary, of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the grace period.

Third Party Payment of Premiums or *Cost Sharing*

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

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

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

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

Misstatement of Age

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

Change or Misstatement of Residence

If you change your *residence*, you must notify the Health Insurance Marketplace or log into your Ambetter *member* portal to process your changes via Ambetter's *Enhanced Direct Enrollment* tool of your new *residence* within 60 calendar 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* application for coverage under this *contract,* we have the right to rerate the *contract* back to the original *effective date*.

COST SHARING FEATURES

Cost Sharing Features

Ambetter may review your service selections and at our option, we may offer rebate(s) when we determine higher quality and lower costs, evidence-based selection(s) were actively chosen by you. We will pay benefits for *covered services* as described in your *Schedule of Benefits* and the Major Medical Expense Benefits section of this *contract.* 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 healthcare 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 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 to a provider*,* by each/all *members* before any benefits are provided or payable. The *deductible amoun*t does not include any *copayment amount* or *coinsurance* amount. Not all *covered service expenses* are subject to the *deductible amount*. See your *Schedule of Benefits* for more details. *Deductible amounts* are applied for a calendar year and do not roll over to the next calendar year.

Copayments

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

Coinsurance Amount

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

Maximum Out-of-Pocket

You must pay a provider any required *copayment*s or *coinsurance amounts* required until you reach the *maximum out-of-pocket amount* shown in your *Schedule of Benefits*. After the *maximum out-of-pocket amount* is met for an individual, we will pay 100 percent of the cost for *covered services*. The

family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket amount*. For the family *maximum out-of-pocket amount*, once a *member* has met the individual *maximum out-of-pocket amount*, the remainder of the family *maximum out-of-pocket amount* can be met with the combination of any one or more *members*' *eligible expenses*.

Refer to your *Schedule of Benefits* for *Coinsurance* Percentage and other limitations.
The amount provided or payable will be subject to:

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

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

Non-Network Liability and Balance Billing

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

Health Savings Account (HSA)

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

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

This Evidence of Coverage is administered by Ambetter from Sunshine Health and underwritten by Celtic Insurance, Inc. Neither entity is an HSA trustee, HSA custodian or a designated administrator for HSAs. Celtic Insurance, Inc., its designee and its affiliates, including Ambetter from Sunshine 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.

ACCESS TO CARE

Primary Care Physician (PCP)

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

1. Family practitioners
2. General practitioners
3. Internal medicine
4. Nurse practitioners*
5. *Physician* assistants
6. Obstetricians/gynecologists
7. Pediatricians (for children)

*If you choose a nurse practitioner as your *PCP*, your benefit coverage and *copayment amounts* are the same as they would be for services from other *network providers*. See your *Schedule of Benefits* for more information. You may obtain a list of *network primary care physicians* at our website and using the “Find a Provider” function or by contacting our *Member* Services department.

You should get to know your *PCP* and establish a healthy relationship with them. Your *PCP* will:

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

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

Contacting Your Primary Care Physician

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

Should you need care outside of your *PCP's* office hours, you should call your *PCP's* office for information on receiving after hours care in your area. If you have an urgent medical problem or question or cannot reach your *PCP* during normal office hours, call our nurse advice line at 1-877-687-1169 (Relay FL 800-955-8770) 24 hours a day, seven days a week. 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.

Ambetter Telehealth* is our free 24-hour access to in-*network* Ambetter healthcare providers when you have a non-*emergency* health issue. It's available to use when you're at home, in the office or even on vacation. Before you start using Ambetter Telehealth, you will need to set up your account at AmbetterTelehealthFL.com.

*Ambetter does not provide medical care. Medical care is provided by individual providers. $0 Telehealth *copay* does not apply to plans with HSA until the *deductible* is met.

Changing Your Primary Care *Physician* (PCP)

You may change your *network primary care physician* for any reason, but not more frequently than once a month, by submitting a written request, online at our website at Ambetter.SunshineHealth.com, or by contacting our office at the number shown on your identification card. The change to your *network primary care physician* of record will be effective no later than 30 calendar days from the date we receive your request.

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 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. 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. Note: Services received from *non-network providers* are generally not *covered services* under this *contract* except when *balance billing protections* apply to a *covered service* provided by a *non-network provider*. If you receive *covered services* from *non-network* providers that are not subject to *balance billing protections*, benefits will be calculated in accordance with the terms of this *contract* for *non-network* providers.

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

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 experience an emergency condition, call 911 or go the nearest emergency room. Be sure to a call us and report your emergency within one business day. You do not need prior authorization for emergency services.

Continuity of Care

Under the federal No Surprises Act, if a member is a continuing care patient with respect to a network provider and the contractual relationship with the provider is terminated, such that the provider is no longer in the network; or benefits are terminated because of a change in the terms of the participation of the provider, as it pertains to the services the member is receiving as a continuing care patient, then we will:

1. Notify the member on a timely basis of the termination and their right to elect continued transitional care from the provider.
2. Provide the member with an opportunity to notify us of the member's need for transitional care; and
3. Permit the member to elect to continue to have their benefits for the course of treatment relating to their status as a continuing care patient during the period beginning on the date on which the notice described in (1) is provided and ending on the earlier of:
    a. 90 days after the notice described in (1) is provided; or
    b. the date on which such member is no longer a continuing care patient with respect to the provider.

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:

1. New technology
2. New medical procedures
3. New drugs
4. New devices
5. New application of existing technology

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

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

Preferred Partnerships

As innovative technologies and solutions are established in market under expedited research and development, we may elect to offer, at our discretion, new services or preferred partnerships designed to improve access to care and enhance *care management*. Ambetter will provide access to *third party* services at preferred or discounted rate. The preferred or discounted rates to these

services may be communicated to all *members* by email, mail or phone promotions. The preferred partnerships are optional benefits to all *members*.

Hospital Based Providers

When receiving care at a network hospital it is possible that some hospital-based providers may not be network providers. If you provide notice and consent to waive *balance billing* protections, you may be responsible for payment of all or part of the balance bill. Any amount you are obligated to pay to the non-network provider in excess of the eligible expense will not apply to your deductible amount or maximum out-of-pocket amount.

MAJOR MEDICAL EXPENSE BENEFITS

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

Acquired Brain Injury Services

Benefits for eligible service expenses incurred for medically necessary treatment of an *acquired brain injury* will be determined on the same basis as treatment for any other physical condition, if such services are necessary as a result of and related to an *acquired brain injury* and include,

1. Cognitive *rehabilitation therapy*,
2. cognitive communication therapy,
3. neurocognitive therapy and rehabilitation.
4. neurobehavioral, neuropsychological,
5. neurophysiological and psychophysiological testing and treatment.
6. neurofeedback therapy,
7. remediation required for and related to treatment of an *acquired brain injury*,
8. 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-a*cute 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 reasonable expenses related to periodic reevaluation of the care of an individual covered who:

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

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

Ambulance Services

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 emergency condition, subject to other coverage limitations discussed below:

1. In cases where the member is experiencing an emergency condition, to the nearest hospital that can provide services appropriate to treat the member's emergency condition.
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 Sunshine Health.
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.

Non-emergency air ambulance services require prior authorization. Prior authorization is not required for air ambulance services when the member is experiencing an emergency condition. **NOTE**: You should not be balance billed for covered 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 condition or,*
2. Those situations in which the *member* is in a location that cannot be reached by ground ambulance.

Exclusions:
No benefits will be paid for:

1. Air ambulance services covered and paid by a local governmental or municipal body, unless otherwise required by law.
2. Non-emergency air ambulance services unless prior authorization is obtained.
3. Air ambulance services:
    a. Outside of the 50 United States and the District of Columbia.
    b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
    c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States.
4. Air ambulance services provided for a member's comfort or convenience.
5. Non-emergency air transportation, excluding air ambulances (for example, commercial flights).

Ground and Water Ambulance Service Benefits

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

1. In cases where the member is experiencing an emergency condition, to the nearest hospital that can provide emergency services appropriate to treat the member's emergency condition.
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 *hospital*s or between a *hospital* and skilled nursing or *rehabilitation facility*, when *authorized* by Ambetter from Sunshine Health.
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 Florida law, if you receive services from non-network ambulance providers, you may be balance billed. Unless otherwise required by Federal or Florida law, if you receive services from non-*network* ambulance providers, you may be *balance billed*.

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, ride sharing).

Autism Spectrum Disorder Benefits

Coverage is provided for *autism spectrum disorders* when prescribed by a *physician* or *behavioral health* practitioner and includes the following:
1. evaluation and assessment services.
2. *applied behavior analysis* therapy.
3. behavior training and behavior management.
4. speech therapy.
5. occupational therapy.
6. physical therapy.
7. psychiatric care such as counseling services provided by a licensed psychiatrist, licensed psychologist, licensed professional counselor or licensed clinical social worker.
8. *habilitation services*, for individuals with a diagnosis of *autism spectrum disorder*; or
9. 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*. See the *Schedule of Benefits* for benefit levels.

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.

Bone Marrow Transplant Services

Bone marrow transplant services are subject to the coverage terms related to transplant services above. In addition, we will not exclude coverage for bone marrow transplant procedures recommended by the referring *physician* and the treating *physician* under this *contract*'s exclusion for *experimental or investigational treatment(s)* or *unproven services* if the procedure is identified in Section 59B-12.001 of the Florida Administrative Code.

Costs associated with the bone marrow donor are covered to the same extent and limitations as costs associated with the insured, except the reasonable costs of searching for the donor may be limited to *immediate family members* and the National Bone Marrow Donor Program.

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:

1. Better understand and manage your health conditions.
2. Coordinate services.
3. 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 *primary care physician (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.

Child Health Supervision Services

The following *covered service* is provided for an *eligible child* in accordance with the Florida Child Health Assurance Act which includes *covered services* from the moment of birth to age 16 years. A waiver of the *deductible amount* applies to all *eligible expenses* for *Child Health Supervision Services*.

Child Health Supervision Services means *physician*-delivered or *physician*-supervised services. These services do not include *hospital* charges.

Child Health Supervision Services include periodic visits, which shall include:

1. History
2. Physical Examination
3. Developmental Assessment
4. Anticipatory Guidance
5. Appropriate Immunizations
6. Laboratory Testing

These services and periodic visits will be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

Eligible expenses for *child health supervision services* are limited to one visit payable to one provider for all the services provided at each visit.

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 United States 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:
    a. The investigational item or service itself.
    b. 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
    c. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Phase I and II clinical trials must meet the following requirements:

1. 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
2. The insured is enrolled in the clinical trial. This section shall not apply to insureds who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

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

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. An NIH Cooperative Group or Center.
6. The FDA in the form of an investigational new drug application.
7. The federal Departments of Veterans' Affairs, Defense, or Energy.
8. An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects; or
9. A qualified non-governmental research entity that meets the criteria for NIH Center support grant eligibility.

In a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to, or superior, non-*investigational treatment* alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational alternatives.

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

Participation in clinical trials is subject to prior authorization requirements as outlined in this *contract*.

Diabetic Care

Benefits are available for *medically necessary* services and supplied used on the treatment of persons with gestational, type I or type II diabetes.

Covered service expenses include, but are not limited to,

1. examinations including podiatric examinations.
2. routine foot care such as trimming of nails and corns.
3. laboratory and radiological diagnostic testing.
4. self-management equipment, and supplies such as urine or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles.
5. orthotics and diabetic shoes.
6. urinary protein/microalbumin and lipid profiles.
7. educational health and nutritional counseling for self-management, eye examinations, and prescription medication; and
8. one retinopathy examination screening per year.

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

We will allow one pair of diabetic footwear without prior authorization per benefit period, and any other subsequent pairs will require prior authorization for medical necessity.

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:

1. Services provided in an Outpatient Dialysis Facility or when services are provided in the Home.
2. Processing and administration of blood or blood components.
3. Dialysis services provided in a *hospital*.
4. Dialysis treatment of an acute or chronic kidney ailment which may include the supportive use an artificial kidney machine.

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

Durable Medical Equipment, Medical and Surgical Supplies, Orthotic Devices and Prosthetics

The supplies, equipment and appliances described below are *covered services* under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is *medically necessary* in your situation or needed to treat your condition, reimbursement will be based on the maximum *allowed amount* for a standard item that is a *covered service*, serves the same purpose, and is *medically necessary*. Any expense that exceeds the maximum allowable 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 our durable medical equipment 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.

All types of *durable medical equipment* and supplies are subject to *prior authorization* as outlined by this *contract*. Please see your Schedule of Benefit for benefit levels or additional limits.

Disposable Medical Supplies

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

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. Augmentative communication devices are covered when we approve based on the *member's* condition.
9. *Medically necessary* corrective footwear, *prior authorization* may be required.

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

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

Medical and Surgical Supplies

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

Covered Services may include, but are not limited to:

1. Allergy serum extracts.
2. Chem strips, Glucometer, Lancets.
3. Clinitest.
4. Needles/syringes.
5. Ostomy bags and supplies except charges such as those made by a pharmacy for purposes of a fitting are not *covered services*.

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

1. Adhesive tape, band aids, cotton tipped applicators.
2. Arch supports.
3. Doughnut cushions.
4. Hot packs, ice bags.
5. Vitamins (except as provided for under Preventive Care Expense Benefits provision).

6. Med-injectors.
7. Items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

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 device is billed with it, but not if billed separately.

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

1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.
10. Devices for correction of positional plagiocephaly
11. Orthopedic shoes
12. Standard elastic stockings

Orthotic devices may be replaced once per year per *member* when *medically necessary* in the *member's* situation. However, additional replacements will be allowed for members when *medically necessary*, or for any *member* when a device is damaged and cannot be repaired.

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

1. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
2. Garter belts, and other supplies not specifically made and fitted (except as specified under the Medical Supplies provision).

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. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
7. Restoration prosthesis (composite facial prosthesis).
8. Wigs (not to exceed one per calendar year).
9. Cochlear implant and Bone Anchored Hearing Aids.

Exclusions:
Non-covered Prosthetic appliances include but are not limited to:

1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Wigs when purchased through other than a health plan DME provider.

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 calendar days of enrollment or agreement to participate in a *surrogacy arrangement*, send us written notice of the *surrogacy arrangement* to us at *Member* Services, P.O. Box 459089 Fort Lauderdale, FL 33345-9089. In the event that a *member* fails to comply with this provision, we reserve our right to enforce this provision on the basis of fraud, misrepresentation or false information, up to and including recoupment of all benefits that we paid on behalf of the *surrogate* during the time that the *surrogate* was insured under our *contract*, plus interest, attorneys' fees, costs and all other remedies available to us.

Emergency Services

If you experience an emergency condition, you should call 911 or head straight to the nearest emergency room. We cover emergency services both in and out of our service area. We cover these services 24 hours a day, seven days a week.

NOTE: Some providers that provide *emergency* services may not be contracted with Ambetter. These services are subject to *balance billing protections* and the *non-network provider* may not *balance bill* you for the difference between our *allowed amount* and the provider's *billed amount*.

Essential Health 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.

Family Planning and Contraception

Family planning/contraception benefits are covered under preventive care, without cost sharing when provided by a network provider and when the care is legal under applicable law. These benefits may include the following for adolescent and adult women, in accordance with the most recent guidelines supported by Health Resources and Services Administration (HRSA):

1. The full range of contraceptives currently identified by the U.S. Food and Drug Administration (FDA), including:
    a. sterilization surgery for women,
    b. implantable rods,
    c. copper intrauterine devices,
    d. intrauterine devices with progestin (all durations and doses),
    e. injectable contraceptives,
    f. oral contraceptives (combined pill),
    g. oral contraceptives (progestin only),
    h. oral contraceptives (extended or continuous use),
    i. the contraceptive patch,
    j. vaginal contraceptive rings,
    k. diaphragms,
    l. contraceptive sponges,
    m. cervical caps,
    n. condoms,
    o. spermicides,
    p. emergency contraception (levonorgestrel) and
    q. emergency contraception (ulipristal acetate).
2. 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 necessary.

3. 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).
4. Instruction in fertility awareness-based methods, including lactation amenorrhea.

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

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

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

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

Custodial care services are not covered under this *contract*, See your *Schedule of Benefits* for benefit levels or additional limits.

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

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

Home Health Care Service Expense Benefits

Covered Services and supplies for *Home Healthcare* are covered when your *physician* indicates you are not able to travel for appointments to a medical office. Coverage is provided for *medically necessary in-network* care provided at the *member's* home and includes the following:

1. *Home health aide services,* only if provided in conjunction with a *physician medically necessary* skill order that must be provided by a skilled registered nurse or licensed practical nursing services. Skilled services of a registered nurse or licensed practical nurse rendered on an outpatient basis.

2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.* Please refer to your *Schedule of Benefits* for any limits associated with this benefit.
3. Intravenous medication and pain medication. Intravenous medication and pain medication are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

4. Hemodialysis, and for the processing and administration of blood or blood components.
5. *Necessary medical supplies*.
6. Rental or purchase of *medically necessary durable medical equipment* at the discretion of the plan.

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 that 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. Home health care services not in conjunction with a registered or licensed practical nurse and home health aide are not covered. Each eight hour period of home health aide services will be counted as one visit.

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

Home health care services and benefits are subject to *prior authorization* requirements as outlined in this *contract*.

Hospice Care Service Expense Benefits

Hospice care benefits are allowable for a *terminally ill member* receiving *medically necessary* care under a *hospice* care program or in a home setting.

Covered services include:
1. Room and board in a *hospice* while the *member* is an *inpatient.*
2. Occupational therapy.
3. Speech-language therapy.
4. The rental of medical equipment while the *terminally ill covered person* 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.*

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

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

Benefits for *hospice* inpatient, home and outpatient care is subject to *prior authorization* as outlined in this *contract*.

Respite care is covered on an *inpatient* or home basis to allow temporary relief to family members from the duties of caring for a covered person under *hospice* care. Respite days that are applied toward the *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.

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.

Long Term Acute Care (LTACH)

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

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

1. Complex wound care:
    a. Daily physician monitoring of wound
    b. Wound requiring frequent complicated dressing changes, and possible repeated debridement of necrotic tissue.
    c. Large wound with possible delayed closure, draining, and/or tunneling or high output fistulas.
    d. Lower extremity wound with severe ischemia.
    e. Skin flaps and grafts requiring frequent monitoring.
2. Infectious disease:
    a. Parenteral anti-infective agent(s) with adjustments in dose
    b. Intensive sepsis management
    c. Common conditions include osteomyelitis, cellulitis, bacteremia, endocarditis, peritonitis, meningitis/encephalitis, abscess and wound infections.
3. Medical complexity:

a. Primary condition and at least two other actively treated co-morbid conditions that require monitoring and treatment.
b. Common conditions include metabolic disorders, stroke, heart failure, renal insufficiency, necrotizing pancreatitis, emphysema (COPD), peripheral vascular disease, and malignant/end-stage disease.

4. Rehabilitation:
   a. Care needs cannot be met in a *rehabilitation* or *skilled nursing facility.*
   b. Patient has a comorbidity requiring acute care.
   c. Patient is able to participate in a goal-oriented *rehabilitation* plan of care.
   d. Common conditions include CNS conditions with functional limitations, debilitation,
   e. Amputation, cardiac disease, orthopedic surgery
5. Mechanical ventilator support:
   a. Failed weaning attempts at an acute care facility
   b. Patient has received mechanical ventilation for 21 consecutive days for 6 hours or more per day.
   c. Ventilator management required at least every 4 hours as well as appropriate diagnostic services and assessments.
   d. Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions.
   e. Patient is hemodynamically stable and not dependent on vasopressors.
   f. Respiratory status is stable with maximum PEEP requirement 10 cm H2O, and FiO2 60% or less with O2 saturation at least 90%
   g. Common conditions include complications of acute lung injury, disorders of the central nervous and neuromuscular systems, and cardiovascular, respiratory, and pleural/chest wall disorder.
   h. Patient continues to meet the criteria above and does not meet the criteria to be transitioned to alternate level of care.

LTACH benefits are subject to *prior authorization* requirements as outlined in this *contract*.

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.

Maternity Care

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. We do not require that a *physician* or other healthcare provider obtain *prior authorization* for delivery. An *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require *prior authorization*. *Prior authorization* is required for all elective c-sections.

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

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

2. *Physician* Home Visits and Office Services.
3. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
4. *Complications of pregnancy*.
5. *Hospital* stays for other *medically necessary* reasons associated with maternity care.
6. For medical services or supplies for maternity deliveries at home, required for medical professional or *medically necessary* treatment.

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

Medical 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 jawbone and is *medically necessary* to attain functional capacity of the affected part.
   c. Oral/surgical correction of accidental injuries.
   d. Treatment for Temporomandibular Joint Disorder (TMJ), including removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services.
   e. Treatment of non-dental lesions, such as removal of tumors and biopsies.
   f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
   g. Surgical procedures that are *medically necessary* to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.
   h. *Reconstructive surgery* to correct significant deformities caused by congenital or developmental abnormalities, *illness*, *injury* or an earlier treatment in order to create a more normal appearance.
2. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* or office charges for dental care, rendered by a dentist, regardless of whether the services are provided in a participating *hospital*, surgical center or office, provided to the following members:
   a. A *member* under the age of eight.
   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.

If you purchased the adult dental rider, please refer to the adult dental covered benefits section.

Medical Foods

We cover medical foods and formulas for:

1. Outpatient total parenteral nutritional therapy
2. Nutritional Counseling
3. Outpatient elemental formulas for malabsorption
4. Dietary formula (when medically necessary and prescribed by a network medical practitioner/provider and administered by enteral tube feedings or when medically necessary for the treatment of Phenylketonuria (PKU) and inborn errors of metabolism)

Coverage also includes other heritable diseases, regardless of the formula delivery method. 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.

In addition, inpatient and outpatient benefits will be provided for up to two months for medically necessary pasteurized donor human milk when prescribed by an infant's pediatrician or licensed pediatric provider stating that the infant is medically or physically unable to receive maternal human milk or participate in breastfeeding or the infant's mother is medically or physically unable to produce maternal human milk in sufficient quantities.

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

Low-Protein Food Products for Treating Inherited Metabolic Diseases

Low-protein food products for treating certain inherited metabolic disease are covered. Inherited metabolic diseases are diseases caused by an inherited abnormality of body chemistry. Low-protein food products are foods that are especially formulated to have less than 1 gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. Low protein food products do not include natural foods that are naturally low in protein.

Benefits for low-protein food products are limited to treating the following diseases:

1. Phenylketonuria (PKU)
2. Maple Syrup Urine Disease (MSUD)
3. Methylmalonic Acidemia (MMA)
4. Isovaleric Acidemia (IVA)
5. Propionic Acidemia
6. Glutaric Acidemia

7. Urea Cycle Defects
8. Tyrosinemia

Medical and Surgical Expense Benefits

Covered Services provided under this provision are subject to all other terms and conditions of the *contract*, including the Deductible Amount and Cost Sharing provisions. Covered services include, but are not limited to, prior authorizations and charges:

1. For *surgery* in a *physician's* office, an inpatient facility, an outpatient facility or a surgical facility, including services and supplies.
2. For medical services in and office or facility that is provided by a licensed *medical practitioner, or specialist physician* including consultations and *surgery* related services.
3. For *durable medical equipment, prosthetic devices, orthotic devices* or other *necessary medical supplies* following medical or surgical procedure such as crutches, orthopedic splints, braces or casts. Please see the Durable Medical Equipment provision of this contract.
4. For pre-surgical and post-surgical procedures and testing, including but not limited to, diagnostic services using radiologic, ultra-sonographic, or laboratory services.
    a. Laboratory tests or radiological examinations done on an outpatient basis in a *hospital* or other facility accepted by the *hospital* before *hospital* confinement or outpatient *surgery* or procedures. The tests must be for the same bodily *illness* or *injury* causing the *member* to be *hospitalized* or to have the outpatient *surgery* or procedure.
    b. Bone density studies
    c. Clinical laboratory tests
    d. Gastrointestinal laboratory procedures
    e. Pulmonary function tests
    f. Genetic testing
    g. For *medically necessary* genetic or molecular cancer testing, including but not limited to, tumor mutation testing, next generation sequencing, hereditary germline mutation testing, pharmacogenomics testing, whole exome, genome sequencing and biomarker testing.
5. For chemotherapy (including oral chemotherapy), inhalation therapy, infusion therapy, and radiation therapy or treatment in a hospital or office setting.
6. For hemodialysis and the charges by a *hospital* or facility for processing and administration of genetic testing, blood or blood components, including cost of blood, blood plasma and blood plasma expanders, which is not replaced by or for you.
7. For the cost and administration of anesthesia, oxygen, drugs, medications and biologicals.
8. For medically necessary dental surgery due to:
    a. An accidental *injury* which results in damage to natural teeth. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
    b. *Surgery* to correct a functional defect which results from a congenital and/or acquired disease or anomaly.
    c. Cleft lip and cleft palate for an eligible *member*. *Covered services* include medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the treating *physician* or surgeon and such *physician* or surgeon certifies that such services are *medically necessary* and consequent to treatment of the cleft lip or cleft palate.
    d. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* charges for dental care, rendered by a dentist, provided to the following *members*:

i. A *member* whose treating *medical practitioner* in consultation with the dentist, determines the *member* has a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or
ii. A *member* who has one or more medical conditions that would create significant or undue medical risk for the *member* during delivery of any dental treatment or *surgery* if not rendered in a *hospital* or ambulatory surgical center.
iii. Necessary dental treatment is that which, if left untreated, is likely to result in a medical condition. Use of general anesthesia in a *hospital* or ambulatory surgical center is subject to *prior authorization*. Please call Member Services to confirm your benefits for the use of general anesthesia in a *hospital* or ambulatory surgical center.

9. For infertility counseling and planning services when provided by a *network* provider and testing to diagnose infertility.
10. For *surgery*, excluding tooth removal, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.** See your *Schedule of Benefits* for benefit levels or additional limits.
11. For medically necessary reconstructive or cosmetic *surgery* including, but not limited to:
    a. 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 lymphedema.
    b. reconstructive *surgery* for craniofacial abnormalities.
12. For *medically necessary chiropractic care* or manipulative therapy treatment on an outpatient basis only.
13. For routine patient care for *members* enrolled in an eligible cancer clinical trial that is deemed an *experimental or investigational* treatment if the services provided are otherwise considered *covered services* under this *contract*. See the Clinical Trial Coverage provision of this *contract*.
14. For X-rays, Magnetic Resonance Imaging (MRI), Computed Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT), and other diagnostic services. See Radiology, Imaging and Other Diagnostic Testing provision of this *contract*.
15. For *medically necessary* services for complications arising from medical and surgical conditions.
16. For *medically necessary* biofeedback services.
17. *Covered service expenses* are permitted when a *member* receives services from a *network provider* specializing in obstetrics and gynecology for obstetrical or gynecological care or if *medically necessary* follow-up care is detected at the visit without a referral from *the member's PCP*.
18. For the following types of medically necessary implants and tissue grafts:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements; and
    e. Implantable prosthetic lenses, in connection with cataracts.
    f. Skin grafts

19. For *covered services* for *medically necessary* diagnosis and treatment of osteoporosis for high-risk *members*, including, but not limited to, estrogen-deficient *members* who are at clinical risk for osteoporosis, *members* who have vertebral abnormalities, individuals who are receiving long-term hyperparathyroidism, *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis, and *members* who have a family history of osteoporosis.
20. For dermatology services which are limited to the following: *medically necessary* minor *surgery*, tests, and office visits provided by a dermatologist who is a *network provider*.
21. Mammograms as follows:
    a. A baseline mammogram for any *covered person* who is 35 to 40 years of age.
    b. A mammogram every two years for any *covered person* who is 40 to 50 years of age, or older, or more frequently based on the patient's *physician's* recommendations.
    c. A mammogram every year for any *covered person* who is 50 years of age or older.
    d. A mammogram based upon a *physician*'s recommendation for any *covered person* who is at risk for breast cancer because of personal medical history, genetic history, or family history of breast cancer.
    e. Mammogram surveillance for breast cancer patients.
    f. Diagnostic mammogram after abnormal screening mammogram.
22. For *medically necessary* genetic blood tests.
23. For all *medically necessary* immunizations, monitoring, screenings, re-screenings and laboratory testing for a newborn in the early detection, diagnosis and intervention of a condition or disorder. This also includes, but not limited to, hearing or audiological services, follow-up examinations and pulse oximetry.
24. For *medically necessary* allergy testing and treatment including allergy injections and serum.
25. For medically necessary telehealth services. Telehealth services not provided through Virtual 24/7 Care would be subject to the same cost sharing as the same health care services when delivered to a member in person.
26. Well childcare examinations, including *Child Health Supervision Services*, based on American Academy of Pediatric Guidelines.
27. For respiratory, pulmonary, cardiac, physical, occupational, and speech therapy services. Please see the Habilitation, Rehabilitation and Extended Care Facility Expense Benefits provision of this *contract.*
28. For the treatment of breast cancer by dose-intensive chemotherapy 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.
29. For cancer screenings, as follows:
    a. A pelvic examination and pap smear for any nonsymptomatic woman
    b. A prostate examination and laboratory tests for cancer for any nonsymptomatic man
    c. A colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic member
30. For the provision of nonprescription enteral formulas and food products required for members with inherited diseases of amino acids and organic acids. Such coverage shall be provided when the prescribing health care professional has issued a written order stating that the enteral formula or food product is *medically necessary*. Coverage for inherited diseases of amino acids and organic acids shall, in addition to the enteral formula, include food products modified to be low protein.

31. Newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.
32. 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.
33. For services associated with human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation or transplant procedures.
34. For testing of pregnant women and other members for lead poisoning.
35. For *medically necessary* footcare treatment that may require surgery; *prior authorization* may be required.

If your provider has the capability, your coverage will include online visit services. *Covered services* include a medical consultation using the internet via a webcam, chat or voice. Non-covered services include, but are not limited to, communications used for:

1. Reporting normal laboratory or other test results
2. Office appointment requests
3. Billing, insurance coverage or payment questions
4. Requests for referrals to doctors outside the online care panel.
5. Benefit precertification
6. Physician to physician consultation

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

Medical Vision Services

Eye examinations for the treatment of medical conditions of the eye are covered when the service is performed by a participating *network* provider (optometrist or ophthalmologist). *Covered services* include office visits, testing, and treatment of eye conditions producing symptoms that if left untreated may result in the *loss* of vision.

Excluded services for routine and non-routine vision include:

1. Visual Therapy.
2. Any vision services, treatment or material not specifically listed as a *covered service*.
3. Low vision services and hardware for adults; and
4. Non-*network* care, except when *prior-authorize*d

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

If you have elected additional Adult Vision Benefits, please refer to the Adult Vision Benefits sections of this contract.

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.

Services will be provided on an inpatient and outpatient basis for the treatment of mental health and substance use disorder diagnoses. These conditions 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 mental health network and do not need a referral from your PCP in order to initiate treatment. Deductible amounts, copayment or coinsurance amounts and treatment limits for covered mental health and substance use disorder benefits will be applied in the same manner as physical health service benefits.

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

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

Covered *Inpatient* and Outpatient mental health 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*; and
6. Electroconvulsive Therapy (ECT).

Outpatient

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

In addition, Integrated *Care management* is available for all of your health care needs, including *behavioral health*. Please call *Member* Services to be referred to a care manager for an assessment.

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.

Newborn Charges

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

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

Newborns' and Mothers' Health Protection Act Statement of Rights

Health Insurance Issuers generally may not, under federal law, restrict benefits for any *hospital* length of stay in 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 cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain *authorization* from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Nutritional Counseling

When deemed medically necessary by your provider, nutritional counseling is a covered benefit.

Outpatient Medical Supplies Expense Benefits

Covered expenses for miscellaneous outpatient medical supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis (as described in the Major Medical Expense Benefits provision), or basic artificial limbs (but not the replacement thereof, unless required by a physical change in the covered person and the item cannot be modified).
2. For one pair of foot orthotics per year per *covered person*.
3. For the purchase or rental of *medically necessary durable medical equipment*.
4. For the rental of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint *surgery*.
5. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract *surgery*.

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 exam
    a. Refraction.
    b. Dilation.
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. Contact lenses and contact lens fitting fee (in lieu of glasses)
6. 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.SunshineHealth.com or call *Member* Services.

Services not covered:

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

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

Drug Discount, Coupon, Copayment Card or Manufacturer Supplied Prepaid Credit Card

Cost sharing paid on your behalf for any *prescription drugs* with a generic equivalent will not apply toward your plan *deductible* or your *maximum out-of-pocket amount* if a *drug discount, coupon, copayment card or manufacturer supplied prepaid credit* card was used. If there is no generic version of the drug available, or if you have completed the *appeal* process or drug exception process and it has been determined that the brand name drug is the appropriate option, then any *cost sharing* paid on your behalf will count toward your *deductible* and your *maximum out-of-pocket amount*.

Extended Days' Supply Process

Maintenance medications are generally taken daily for chronic and lifelong conditions. Extended days' supply fills (up to 90 calendar days) of select maintenance medications are available exclusively through select pharmacies. For more information, please consult our website.

Formulary or Prescription Drug List

The formulary or *prescription drug* list is a guide to available generic, brand name drugs and some over-the-counter medications when ordered by a *physician* that are approved by the United States 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.SunshineHealth.com (under "For *Member*", "Drug Coverage") or call *Member* Services.

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 online Provider Directory to find a pharmacy near you. You can access the Provider Directory at guide.ambetterhealth.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 in-*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.SunshineHealth.com. You can also request to have a copy mailed directly to you.

Insulin

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

Lock-in Program

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

Mail Order Pharmacy

Mail Order Pharmacy offers a convenient way to receive your prescriptions. Eligible 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, please refer to our Ambetter website. Once on our Ambetter website, click on “For Members”, followed by “Drug Coverage”. Under the “Mail Order” section, you will find details on your in-network mail order pharmacies and next steps for enrollment.

Medication Balance On-Hand

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

Non-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 *Prescription Drug* Exception request process. See “Prescription drug Exception Process” for additional details.

Over-the-Counter (OTC) Prescriptions

We cover a variety of 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.

Prescription Drug Exception Process

Prescription drug exception process is applicable when:

1. The drug is not covered based on our formulary.
2. We are discontinuing coverage of the drug.
3. The prescription drug alternatives required to be used in accordance with a step therapy requirement:
    a. has been ineffective in the treatment; or
    b. has caused an adverse reaction or harm to a member.

Standard exception request

A *member,* a *member's authorized representative* or a *member's* prescribing *physician* may request a standard review of a drug exception decision. The request can be made in writing or via telephone. Within 72 hours of the request being received, we will provide the *member*, the *member's authorized representative* or the *member's* prescribing *physician* with our coverage determination. Should the standard exception request be granted, we will provide coverage of the requested drug for the duration of the prescription, including refills not to exceed the standard duration of treatment as established by clinical guidelines and criteria. Please see the Grievance and Complaints Procedures provision for appeals information.

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 the requested drug. Within 24 hours of the request being received, we will provide the *member*, the *member's authorized representative* or the *member's* prescribing *physician* with our coverage determination. Should the expedited exception request be granted, we will provide coverage of the requested drug for the duration of the exigency.

External exception request review

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

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

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 any mail pharmacy other than CVS Mail or retail pharmacy other than Walgreens Retail. Specialty drugs and other select drug categories are limited to 30-day supplies when dispensed by retail or mail order. Please note that only the 90-day supply is subject to the discounted cost sharing. Eligible maintenance prescriptions filled for less than 90 days are subject to the standard *cost sharing* amount.
12. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
13. Foreign Prescription Medications, except those associated with an *Emergency Medical Condition* while you are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this document if obtained in the United States.
14. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventive treatment is related to *member's* vacation during out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
15. For medications used for cosmetic purposes.
16. For infertility drugs unless otherwise listed on the formulary.
17. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
18. For drugs or dosage amounts determined by Ambetter's Pharmacy and Therapeutics committee to be ineffective, unproven or unsafe for the indication for which they have been

prescribed, regardless of whether such drugs or dosage amounts have been approved by any governmental regulatory body for that use.
19. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
20. For any drug dispensed from a non-lock-in pharmacy while *member* is in lock-in program.
21. For any drug related to *surrogate pregnancy*.
22. For any injectable medication or biological product that is not expected to be self-administered by the *member* at *member's* place of *residence* unless listed on the formulary.
23. Medication refills where a *member* has more than 15 days' supply of medication on hand.
24. Compound drugs unless there is at least one ingredient that requires a prescription.
25. For any prescription or over-the-counter version of vitamin(s) unless otherwise included on the formulary

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.

Self-injectable Drugs

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

Split-Fill Dispensing Program

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

Step Therapy Protocol for Prescription Drugs

Our contract uses a requirement of Step Therapy for certain *prescription drugs*. *We* employ clinical pharmacists who review, research and analyze the efficacy and value of various drugs. Based on their reviews of clinical practice guidelines and recommended treatment of diseases, they recommend specific drugs as the first ones to try when a *member* begins or requires a change in medication therapy. For most people, these medications work well. In the limited instances where one of these medications isn't effective and/or appropriate for a particular *member*, the prescribing *physician* contacts *us* about approving coverage for a different medication. Trying medications in this "step-by-step" fashion is called Step Therapy. This also ensures that drugs are used in the appropriate clinical order for *your* medical condition.

We may provide an exception to a *step-therapy protocol* under the *contract* for a covered *prescription drug* requested by a *member* if:

1. The *member* has previously been approved to receive the *prescription drug* through the completion of a *step-therapy protocol* required by a separate health coverage plan; and
2. The *member* provides documentation originating from the health coverage plan that approved the *prescription drug* indicating that the member's previous health coverage plan paid for the drug on the member's behalf during the days immediately before the request.

3. For exceptions to the "*Step Therapy Protocol* for *Prescription Drugs*", please refer to the "*Prescription Drug* Exception Process" section of this *contract.*

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, to the extent the care is not illegal under applicable law.

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

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

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

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

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

Our Ambetter Health Preventive Services Guide is updated annually and contains detailed information regarding preventive care coverage available to you. It is accessible via our website or by contacting Member Services. Either go to our website directly or if you need to request a paper copy, please contact Member Services for assistance.

Notification
As required by section 2715(d)(4) of the Public Health Service Act, we will provide 60 calendar 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 contact *Member* Services 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.SunshineHealth.com.

Radiology, Imaging and other Diagnostic Testing

Medically necessary radiology services, imaging and tests performed for diagnostic reasons are a covered service (e.g., X-ray, Magnetic Resonance Imaging (MRI), Computed Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT). *Prior authorization* may be required, see your *Schedule of Benefits* for details. **NOTE:** Depending on the service performed, two bills may be incurred – both subject to any applicable *cost sharing* – one for the technical component (the procedure itself) and another for the professional component (the reading/interpretation of the results by a *physician* or other qualified practitioner).

Non-network providers should not bill you for covered services for any amount greater than your applicable cost sharing responsibilities when *balance billing protections* apply to the radiology, imaging, and other diagnostic testing services.

Second Medical Opinion

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

1. Whenever a *surgical procedure* is recommended to confirm the need for the procedure.
2. Whenever a serious *injury* or *illness* exists; or
3. Whenever you feel 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* must 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 *copayment amount* for the consultation. Any lab tests or diagnostic and therapeutic services are subject to the additional *cost sharing.* The plan may allow a second opinion from a *non-network provider*, which will be subject to *prior authorization* and medical necessity review, and the *non-network provider* has to agree to payment rates.

Sleep Studies

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

Social Determinants of Health Supplemental Benefits

Social determinants of health supplemental benefits and services may be offered to 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 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 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.SunshineHealth.com or by contacting *Member* Services.

Transplant Expense Benefits

Covered services for transplant service expenses:
Transplants are a covered benefit when a *member* is accepted as a transplant candidate and pre-*authorized* in accordance with this *contract*. *Prior authorization* must be obtained through the "*Center of* Excellence" before an evaluation for a transplant. We may require additional information such as testing and/or treatment before determining medical necessity for the transplant benefit. *Authorization* must be obtained prior to performing any related services to the transplant *surgery*. Transplant services must 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 *contract* will be provided for both you and the donor. In this case, payments made for the donor will be charged against the enrollee's benefits.
3. If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this *contract* will be provided for you. However, no benefits will be provided for the recipient.
4. If there is a lapse in coverage due to non-payment of premium, no services related to transplants will be paid as a covered benefit.

If we determine that a *member* and donor are an appropriate candidate for *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. Outpatient *covered services* related to the transplant *surgery*, pre-transplant laboratory testing and treatment, such as high dose chemotherapy, peripheral stem cell collection and other immunosuppressive drug therapy, etc.
5. Pre-transplant stabilization, meaning an *inpatient* stay to *medically stabilization* to prepare for a later transplant, whether or not the transplant occurs.
6. The transplant itself including the acquisition cost for the organ or bone marrow when *authorized* through the *Center of Excellence* and services are performed at a 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. (Ambetter.SunshineHealth.com).

These medical expenses are covered to the extent that the benefits remain and are available under the *member's contract*, 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 contract.*

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

1. We will pay for the following services when the enrollee is required to travel more than 75 miles from the *residence* to the *Center of Excellence*:
2. We will pay a maximum of $10,000 per transplant service for the following services:
   a. Transportation for the *member,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence,* in the United States.
   b. When *member* and/or donor is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
   c. Maximum reimbursement for mileage is limited to travel to and from the *member's* home to the transplant facility, and to and from the donor's home to the transplant facility and will be reimbursed at the current IRS mileage standard for miles driven for medical purposes.
   d. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence* in the United States. We will *members* for the proof of costs directly related for transportation and 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 6 months of the date of service in order to be reimbursed.
   e. Incurred costs related to a certified/registered service animal for the transplant enrollee and/or donor.
   f. Please refer to the *member* resources page for *member* reimbursement transplant travel forms and information at Ambetter.SunshineHealth.com.

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

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *medically necessary* transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the *Center of Excellence*.
4. To keep a donor alive for the transplant operation, except when *authorized* through the *Center of Excellence*.
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
6. Related to transplants unauthorized through the *Center of Excellence* and is not included under this provision as a transplant.

7. 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 USFDA oversight. **NOTE:** This exclusion does not apply to bone marrow transplants.
8. The acquisition cost for the organ or bone marrow when provided at an *authorized* facility or not obtained through the *Center of Excellence.*
9. For any transplant services and/or travel related expenses for *member* and donor when performed outside of the United States.
10. The following ancillary items listed below will not be subject to the *member* reimbursement under this *contract*:
    a. Alcohol/tobacco
    b. Car Rental (unless pre-approved by Case Management)
    c. Vehicle Maintenance for motorized and hybrid and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.)
    d. Parking, such as but not limited to hotel, valet or any offsite parking other than *hospital*.
    e. Storage rental units, temporary housing incurring rent/mortgage payments.
    f. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
    g. Speeding tickets
    h. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
    i. For any services related to pet care, boarding, lodging, food, and/or travel expenses; other than those related to certified/registered service animal(s).
    j. Expenses for persons other than the patient and his/her covered companion
    k. Expenses for lodging when *member* is staying with a relative
    l. Any expense not supported by a receipt.
    m. Upgrades to first class travel (air, bus, and train)
    n. Personal care items (e.g., shampoo, deodorant, clothes)
    o. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA pre-check, and early check-in boarding fees, extra baggage fees.
    p. Souvenirs (e.g., t-shirts, sweatshirts, toys)
    q. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type.
    r. All other items not described in the *contract* as *eligible expenses.*
    s. Any fuel costs/charging station fees for electric cars.

Urgent Care Services

Urgent Care services include *medically necessary* services by *network providers* and services provided at an *in-network 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 *in-network* Urgent care center.

Members are encouraged to contact their *primary care physician* for an appointment before seeking care from another provider, but *network urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *primary care physician* is not available and the condition persists, call the Nurse Advice Line, at 1-877-687-1169 24 hours a day, seven days a week. The Nurse Advice Line is available 24 hours a day, seven days a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

Wellness 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. 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.SunshineHealth.com or by contacting *Member* Services by telephone at 877-687-1169 (Relay FL/TTY 1-800-955-8770). 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 automatically 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.

PRIOR AUTHORIZATION

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

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

Prior Authorization Required

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

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

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

Pursuant to the federal No Surprises Act, emergency services received from a non-network provider are covered services that do not require prior authorization from you or your provider.

Prior Authorization (medical and *behavioral health*) requests must be received by telephone, e-fax or provider web portal as follows:

1. At least five calendar days prior to an elective admission as an *inpatient* in a *hospital, extended care* or *rehabilitation facility*, or *hospice* facility, or *residential treatment facility*.
2. At least 30 calendar days prior to the initial evaluation for organ transplant services.
3. At least 30 calendar days prior to receiving clinical trial services.
4. Within one business day of any *inpatient* admission, including emergent *inpatient* admissions.
5. At least five calendar days prior to the start of *home health care* except those *member*s needing *home health care* after *hospital* discharge.

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

1. For urgent concurrent reviews within one calendar day of receipt of the request.
2. For urgent pre-service reviews, within three calendar days from date of receipt of request.
3. For non-urgent pre-service reviews, within 15 calendar days of receipt of the request.
4. For post-service or retrospective reviews, within 30 calendar days of receipt of the request.

You do not need to obtain prior authorization from us or from any other person (including your PCP) in order to obtain access to obstetrical or gynecological care from a medical practitioner in our network who specializes in obstetrics or gynecology. The medical practitioner, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services,

following a pre-approved treatment plan or procedures for making referrals. For a list of participating medical practitioners who specialize in obstetrics or gynecology, contact *Member* Services.

How to Obtain Prior Authorization

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

Failure to Obtain Prior Authorization

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

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

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

Prior Authorization Does Not Guarantee Benefits

Our *authorization* does not guarantee either payment of benefits or the number of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *contract.*

Prior Authorization Denials

Refer to the *complaint* and *Appeals* Procedures section of this *contract* for information on your rights to *appeal* a denied *authorization*.

Requests for Predeterminations

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

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

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

Services from Non- Network Providers

We do not typically cover services received from non-network providers (meaning you will have to pay for the services), except when covered services are provided when *balance billing protections* apply. If a situation arises where a covered service cannot be obtained from a network provider located within a reasonable distance, we may provide prior authorization for you to obtain services from a non-network provider at no greater cost to you than if you went to a network provider. If covered services are not available from a network provider, you or your PCP must request prior authorization from us before you may receive services from a non-network provider. Otherwise, you will be responsible for all charges incurred.

Florida law requires that we provide you with the following disclosure about your health benefit plan coverage. "WARNING: LIMITED BENEFITS WILL BE PAID WHEN NON-*NETWORK* PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-*network* provider for a covered non*emergency* service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to your *contract*'s out-of-*network* reimbursement benefit. Non-*network* providers may bill insureds for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE *COINSURANCE* OR *COPAYMENT* AMOUNT. *Network* providers have agreed to accept discounted payments for services with no additional billing to you other than *coinsurance*, *copayment*, and *deductible* amounts. You may obtain further information about the providers who have contracted with your insurance plan by consulting your insurer's website or contacting your insurer or agent directly."

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

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

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

1. Administered or ordered by a *physician, physician designated, or physician extender;* 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,* except as expressly provided for under the plan administration clause in this *contract*.
2. For any portion of the charges that are in excess of the *eligible expense.*
3. For weight modification or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery, and bariatric surgery, except as specifically covered in the Major Medical Expense Benefits section of this *contract*.
4. For cosmetic breast reduction or augmentation except post-mastectomy for breast cancer and the *medically necessary* treatment of gender dysphoria.
5. For reversal of sterilization and reversal of vasectomies.
6. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
7. For expenses for television, telephone, or expenses for other persons.
8. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
9. For telephone consultations between providers, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
10. For stand-by availability of a *medical practitioner* when no treatment is rendered.
11. For *dental service expenses,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under the Medical and Surgical Expense Benefits provisions.
12. For cosmetic treatment, except for reconstructive surgery that is incidental to or follows surgery or an injury that was covered under the policy or is performed to correct a birth defect.
13. Mental Health Services are excluded:

a. for evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless a plan 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 a parole or probation, unless a plan provider determines such services to be *medically necessary*.
c. Court ordered care or testing or required as a condition of parole or probation. Benefits will be allowed for services that are *medically necessary* and would otherwise be covered under this *contract*.
d. services which are custodial or residential in nature; (e) habilitative services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.

14. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
15. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
16. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
17. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
18. For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this contract.
19. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.
20. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of 90 consecutive days.
21. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is *appeal*ed to the proper governmental agency and the denial is upheld by that agency.
22. For fetal reduction *surgery*.
23. Except as specifically identified as a *covered service expense* under the *contract*, services or expenses for alternative treatments, including acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
24. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or Semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any motorized vehicle or conveyance; racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); rodeo sports; horseback riding

(if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).

25. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or *member* of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
26. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
27. For *illness* or *injury* caused by the acts or omissions of a *third party*, we will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*.
28. For the following miscellaneous items: Artificial Insemination, In Vitro Fertilization, Intra-Cytoplasmic Sperm Injection (ICSI), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT) biofeedback; care or complications resulting from non-covered services; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; health club memberships, unless otherwise covered; home test kits (except where required by federal or state law); care or services provided to a non-enrollee biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; private duty nursing; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service area; sclerotherapy for varicose veins; treatment of spider veins; transportation expenses, unless specifically described in this contract.
29. For diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
30. For penile prosthetic *surgery* or for complications resulting from a penile implant.
31. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status. To facilitate appropriate benefit use and prevent opioid overutilization, *member*'s participation in lock-in status will be determined by review of pharmacy claims.
32. *Surrogacy arrangement*. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a *member*, and any child born as a result of a *surrogacy arrangement*. This exclusion applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
    a. Prenatal care.
    b. Intrapartum care (or care provided during delivery and childbirth).
    c. Postpartum care (or care for the *surrogate* following childbirth).
    d. Mental Health Services related to the *surrogacy arrangement*.
    e. Expenses relating to donor semen, including collection and preparation for implantation.
    f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*.
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*.
    h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement*.
    i. Any complications of the child or s*urrogate* resulting from the *pregnancy*; or
    j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*.
    k. Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except where the

child is the adoptive child of insureds possessing an active policy with us and/ or the child possesses an active policy with us at the time of birth.

33. For any medicinal and recreational use of cannabis or marijuana.
34. For any product that reasonably could be expected to be non-self-administered or for products that should be administered in a medical facility.
35. For all health care services obtained at an Urgent Care Facility that is a *Non-network Provider*, unless *prior authorization* is received.
36. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service* expenses of the Medical and Surgical Expense Benefits provisions.
37. Immunizations that are not *medically necessary* or medically indicated. This includes those used for travel and occupational.
38. For expenses, services, and treatments from a massage therapist to touch and manipulate the muscles and other soft tissues of the body.
39. For expenses, services, and treatments from a Naprapathic *specialists* for conditions caused by contracted, injured, spasmed, bruised, and/or otherwise affected myofascial or connective tissue.
40. For expenses, services, and treatments from a Naturopathic *specialist* for treatment of prevention, self-healing and use of natural therapies.
41. For expenses, services, and treatments related to private duty nursing in an inpatient, outpatient, and home location.
42. For expenses, services, and treatments related to private duty nursing in an *inpatient*, outpatient or home location.
43. Complications resulting from surgeries that arise from a non-covered procedure including those occurring prior to enrollment.
44. While confined primarily in a long-term nursing facility, assisted living facility, or *custodial care*/domiciliary care facility.
45. For the treatment of infertility. Note: Coverage is available for diagnosis and services required to correct underlying medical causes of infertility.
46. For expenses for services related to dry needling.
47. For weight loss programs, gym memberships, exercise equipment, or meal preparation programs.
48. Vehicle installations or modifications which may include, but are not limited to adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.

PLAN ADMINISTRATION

In consideration of the payment of premiums, we will provide coverage for the *member* and any *eligible dependents*. In doing so, we may enter into agreements with providers of health care and such other individuals and entities as may be necessary to enable us to fulfill our obligations under this *contract*.

We agree to provide coverage without discrimination because of race, color, national origin, disability, sex, gender identity, sexual orientation, religion, or any other basis prohibited by law.

Commencement of Coverage

Commencing on the *contract effective date* we agree to provide the coverage stipulated in this *contract* to the *member* and his/her *dependents*, if any. Such coverage begins on the *member's effective date*, which will be the first of the month after the receipt and approval of the application by us, unless this *contract* specifies a date other than the first of the month. We accept no liability for benefits related to expenses incurred prior to your *effective date* or after your termination date, which will be on the last day of the coverage month, except or as specified in the Terms of Renewal provision.

Plan Renewal

This *contract* is guaranteed renewable. Guaranteed renewable means that this *contract* will renew each year on the anniversary date unless terminated earlier in accordance with *contract* terms. You may keep this *contract* in force by timely payment of the required premiums. We may decide not to renew as of the renewal date if:

1. we decide not to renew all contracts issued on this form, with the same type and level of benefits, to residents of the state where you then live; or
2. there is fraud or an intentional material misrepresentation made by or with the knowledge of a member in filing a claim for contract benefits. Rate changes are effective on a member's annual renewal date and will be based on each member's attained age, family structure, geographic region, tobacco usage and benefit plan at the time of renewal. We will notify the member in writing at least 45 calendar days prior to the renewal date of any change in premium rates.

For *members* who have elected the electronic funds transfer option of payment, should premiums change at renewal, we will continue to draft the new monthly premium.

Term of Renewal

We guarantee the *member* the right to renew the *contract* each year, at the *member's* option. However, we may refuse to renew this *contract*, and all coverage provided under this *contract,* if one of the following circumstances has occurred:

1. Failure to timely pay premium in accordance with the terms of the *contract.*
2. We cease offering this *contract* to all *members*.
3. The *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this *contract.*
4. The *member* no longer lives in our geographic *service area.*
5. We elect to discontinue all individual health coverage in the State of Florida; and
6. We elect to discontinue offering individual health coverage through the Health Insurance Marketplace.

With the exception of non-payment of premium or *loss* of eligibility, if we decide to terminate or non-renew this *contract* for any of the reasons set forth in this *contract*, we will give the *member* at least 45 calendar days advance written notice prior to renewal. If we discontinue offering all individual coverage in Florida, we will give all *members* and the Office of Insurance Regulation 180 calendar day's written notice prior to the *contract* non-renewal date.

Termination of This *Contract* by the Member

The *member* may terminate this *contract* at any time with appropriate notice of at least 14 calendar days to either us or the Health Insurance Marketplace. Coverage will terminate on the date specified by the *member*, or 14 calendar days after termination is requested, whichever is later. If the *member* requests termination in fewer than 14 calendar days, and we can effectuate this request in a shorter period of time, then coverage will terminate on the date determined by us. No benefits will be provided as of the *effective date* of termination of this *contract* for whatever reason.

Should the *member* or any covered dependents terminate coverage because of eligibility for Medicaid, Children's Health Insurance Program (CHIP) or a basic health plan or termination is due to the *member* moving from one *qualified health plan* to another during an Annual or Special Enrollment Period, the termination *effective date* will be the day before the *effective date* of the new coverage.

Discontinuance of a Benefit Plan

We may discontinue offering a particular benefit plan to all *members* if:

1. We provide at least one hundred and eighty (180) day notice to each *member* prior to the *contract* renewal date.
2. We offer each *member* the option to purchase any other coverage offered in the individual Health Maintenance Organization (HMO) market; and
3. We act uniformly without regard to any health status-related factor of each *member*.

Discontinuance of All Coverage in the Individual Market

We may discontinue offering all coverage in Florida if:

1. We provide notice to the Office of Insurance Regulation and each *member* and enrollee 180 calendar days prior to renewal; and
2. All health coverage issued or delivered for issuance in Florida is discontinued and coverage under such health coverage is not renewed.

Termination of this Plan by Us

Except for nonpayment of premium or termination of eligibility, we may not cancel or terminate or non-renew this *contract* without giving the *member* at least 45 calendar days written notice. The written notice will state the reason or reasons for the cancellation, termination or non-renewal.

We may terminate this *contract* as of any premium due date if the *member* has not paid the required premium by the end of the Grace Period, as defined in the Grace Period provision. The *member* is liable to us for any unpaid premium for the time the plan was in force.

Upon termination of coverage, we will have no further liability for the payment of any *covered services* provided after the date of the *member's* termination.

Plan Termination Due to Non-Payment of Premium

If the *member* is receiving premium subsidies, the following provision applies:

1. If the required monthly premium is not received by the end of the 90 calendar days Grace Period, we will terminate coverage effective at midnight on the last day of the first month of the three-month grace period.

If the *member* is not receiving premium subsidies, the following provision applies:

1. If the required monthly premium is not received by the end of the 30 calendar days grace period, we will terminate this *contract*, without prior notification, retroactive to the last date for which premium was received, subject to the Grace Period provision. Termination will be effective as of midnight of the date that the premium was due provided, we mail written notice of termination to the *member* prior to 45 calendar days after the date the premium was due.

Termination of Coverage by the Health Insurance Marketplace or Us

The Health Insurance Marketplace may terminate coverage in a *qualified health plan* and will also permit us to terminate coverage for any of the following reasons.

1. *Loss* of eligibility to purchase a *qualified health plan* through the Health Insurance Marketplace.
2. Nonpayment of premiums provided that the grace period has elapsed.
3. Coverage is rescinded.
4. We terminate or are decertified by the Health Insurance Marketplace.
5. An enrollee switches to another *qualified health plan* during an Annual Open Enrollment Period or Special Enrollment Period.

Terms of Renewal

We guarantee the *member* the right to renew the *contract* each year, at the *member's* option. However, we may refuse to renew this *contract,* and all coverage provided under this *contract*, if one of the following circumstances has occurred:

1. The *member* fails to timely pay premium in accordance with the terms of the *contract*.
2. We cease offering this *contract* to all *members.*
3. The *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this *contract*.
4. The *member* no longer lives or works in our geographic *service area;* and
5. We elect to discontinue all individual health coverage in the State of Florida.

With the exception of non-payment of premium or *loss* of eligibility, if we decide to terminate or non-renew this *contract* for any of the reasons set forth in this *contract,* we will give the *member* at least 45 calendar days advance written notice.

Discontinuance

180-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 *and all enrollees* at least 180 calendar 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 and refuse to renew all individual *contracts* in the individual market in the state where you reside, we will provide a written notice to you, all enrollees, and the Commissioner of Insurance at least 180 calendar 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.

Notification Requirements

It is the responsibility of you or your former *dependent member* to notify us within 31 calendar 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.

Continuation

If a *member's* eligibility under this *Contract* would terminate due

1. to the *contract* holder's death,
2. divorce or
3. if other family *member*(s) would become ineligible due to age or
4. no longer qualify as dependents for coverage under this *Contract*.
5. if an Insured person's eligibility for coverage under this *Contract* terminates prior to that Insured being eligible.
6. for Medicare or Medicaid benefits.
7. except for the *contract* holder's failure to pay premium,

that *Member* has the right to continuation of his or her insurance. Coverage will be continued if the Family *Member* exercising the continuation right notifies Ambetter and pays the appropriate monthly Premium within 31 calendar days following the date this *Contract* would otherwise terminate. No evidence of insurability is required to continue coverage.

SUBROGATION AND RIGHT OF REIMBURSEMENT

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

Celtic Insurance Company retains the right to repayment of the full cost of all benefits provided by this plan on behalf of the *member* that are associated with the *third-party injuries*. Celtic Insurance Company's rights of recovery apply to any recoveries made by or on behalf of the *member* from any sources, including but not limited to:

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

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

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

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

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

agreement, and regardless of whether such payment will result in a recovery to the *member* which is insufficient to make the *member* whole or to compensate the *member* in part or in whole for the damages sustained);

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

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

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

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

COORDINATION OF BENEFITS

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

It is a contractual provision of a majority of health benefit *contracts*. Ambetter from Sunshine Health complies with Federal and state regulations for COB and follows COB guidelines published by National Association of Insurance Commissioners (NAIC).

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

"Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

"Plan" as used in this section is a form of coverage written on an expense-incurred basis with which coordination is allowed.

The term "Plan" includes:

1. Group and non-group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group and individual HMO insurance and other prepayment, group practice and individual practice plans, and blanket *contracts*, except as excluded below.
2. Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type *contracts*.
3. *Hospital*, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid.

The plan does not include:

1. Blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
2. Plan does not include coverage, which by law, provides benefits that are in excess of those of any private insurance plan or other nongovernment plan.

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

1. The Plan has no order of benefits rules, or its rules differ from those required by regulation; or

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

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

Order of Benefit Determination Rules
The first of the rules listed below in paragraphs 2-9 that applies will determine which plan will be primary:

1. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. A plan may consider benefits paid or provided by another plan in determining its benefits only when it is secondary to that *other plan*.
2. If the *other plan* does not contain a coordination of benefits provision that is consistent with this provision, then it is always primary. There are two exceptions:
   a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the *contract* holder; and
   b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987, which provides excess major medical benefits intended to supplement any basic benefits on a *covered person* may continue to be excess to such basic benefits.
3. If the person receiving benefits is our *member* and is only covered as an eligible dependent under the *other plan*, this *contract* will be primary.
4. However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a dependent of an active employee (a Medicare beneficiary also has another group plan), then the order of benefit determination is:
   a. First, benefits of a plan covering a person as an employee, *member*, or subscriber.
   b. Second, benefits of a plan of an active worker covering a person as a dependent.
   c. Third, Medicare benefits.
5. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
   a. If both parents have the same birthday, the plan which covered the parent longer will be primary.
   b. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the *other plan* does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the *other plan* will determine which plan is primary.
6. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
   a. The plan of the parent who has custody will be primary.
   b. If the parent with custody has remarried, and the child is also covered as a child under the stepparent's plan, the plan of the parent with custody will pay first, the stepparent's plan will pay second, and the plan of the parent without custody will pay third.

7. If a child's coverage is based on a court decree, and the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child and if the entity obliged to pay or provide the benefits of the policy or plan of that parent has actual knowledge of those terms, the benefits of that policy or plan are determined first. The parent with responsibility that has no health care coverage for the dependent child's health care expenses, but that parent's *spouse* does, that parent's *spouse's* plan is the primary plan.
8. If the person receiving services is covered under one plan as an active employee or *member* (i.e., not laid-off or retired), or as the *spouse* or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the *spouse* or child of such a laid-off or retired employee, the plan that covers such person as an active employee or *spouse* or child of an active employee will be primary. If the *other plan* does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
9. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination
When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Ambetter's maximum allowable benefit for each c*overed service*. Also, the amount Ambetter pays will not be more than the amount Ambetter would pay if Ambetter were primary. As each claim is submitted, Ambetter will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

In the event of multiple forms of coverage, Ambetter reserves the right to reduce or refuse to pay benefits otherwise payable on the account of existing of similar benefits provided under insurances policies issued by the same or another insurer, in accordance with state and federal laws. As a condition of coordinating benefits, the insurers together pay 100 percent of the total reasonable expenses actually incurred of the type of expense within the benefits described in the policies and presented to the insurer for payment.

Effect of Medicare
Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status and will be adjudicated by us as set forth in this section. When Medicare, Part A and Part B or Part C is primary, Medicare's allowable amount is the highest allowable expense.

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

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

CLAIMS

Notice of Claim

When a *non-participating provider* renders services, notice of a claim for benefits must be given to us. The notice must be in writing, should include the name of the insured and *member* identification number, and any claim will be based on that written notice. The notice must be received by us within 20 calendar days after the date of the *injury* or the first treatment date for the sickness on which the claim is based and may be given to us or your agent. If this required notice is not given in time, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit the notice within the 20 day period and that notice was given as soon as possible, the claim will not be reduced or invalidated.

Proof of Loss

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

How to Submit a Claim

Providers will typically submit claims on your behalf, but sometimes you may need to submit claims yourself for covered services. This may happen if your provider is not contracted with us.

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

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

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

Cooperation Provision

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

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

person or entity to promptly provide to us, or our representative, any information, records or documents requested by us.

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

Time for Payment of Claims

Benefits will be paid as soon as we receive proper *proof of loss*. For services that do not fall under the federal No Surprises Act balance billing protections, we will process all claims or any portion of any claim within 45 calendar days after receipt of the claim. If a claim or a portion of a claim is contested, you or your assignees shall be notified, in writing, that the claim is contested or denied, within 45 calendar days after we receive the claim from you. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim. Upon receipt of the additional information requested you or your assignees, we shall pay or deny the contested claim or portion of the contested claim, within 60 calendar days. For services that fall under the federal No Surprises Act balance billing protections, we will process a clean claim within 30 calendar days of receipt.

"Clean claims" means a claim submitted by you or a provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If we have not received the information, we need to process a claim, we will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information. In those cases, we cannot complete the processing of the claim until the additional information requested has been received. We will make our request for additional information within 30 calendar days of our initial receipt of the claim and will complete our processing of the claim within 15 calendar days after our receipt of all requested information.

We shall pay or deny any claim no later than 120 calendar days after receiving the claim. Payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery. All overdue payments shall bear simple interest at the rate of 10 percent per year.

Upon your written notification, we will investigate any claim of improper billing by a *physician*, *hospital*, or other health care provider. We will determine if you were properly billed for only those procedures and services that the *covered person* actually received. If we determine that you have been improperly billed, we shall notify you and the provider of our findings and shall reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such notification by us, we shall pay to you 20 percent of the amount of the reduction up to $500.

Payment of Claims
We may elect to pay, in our discretion, all or any part of the benefits provided by this *contract* for *hospital*, surgical, nursing, or medical services, directly to the *hospital* or other party providing such services to you. By reserving the right to pay, in our discretion, all or any part of the benefits provided for in this *contract* directly to a *hospital* or other person providing surgical, nursing, or medical services to you, we are not granting any *hospital* or other person rendering surgical, nursing or medical services any right to demand direct payment or any right to enforce any provision of this *contract*; nor are we waiving the Non-Assignment provision of this *contract* set forth below.

Foreign Claims Incurred for Emergency Care
Emergency services are covered services while traveling outside of the United States for up to a maximum of 90 consecutive days from the start of travel, even if enrollment occurs during the period of travel. If travel extends beyond 90 consecutive days, no benefit coverage is provided for the entire period of travel, including the first 90 days.

Claims incurred outside of the United States for emergency services 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.SunshineHealth.com.

The amount of reimbursement will be based on the following:

1. *Member's* Benefit plan and *member* eligibility on date of service
2. *Member's* Responsibility/Share of Cost based on date of service.
3. Currency Rate at the time of completed transaction, Foreign Country currency to United States currency.

Once we have reviewed all the necessary documentation and the claim for emergency services has been processed, a member Explanation of Benefits (EOB) will be mailed. The EOB will identify member responsibility according to the member's policy at the time of travel. If services are deemed as true emergency services, including that they were provided to treat a member's emergency condition, the member will be issued reimbursement payment for any eligible incurred costs, minus member cost share obligation.

Appeal Procedures for Claims
Refer to the Internal *Grievance*, Internal *Appeal*s and External *Appeal*s Procedures provisions of this *contract* for information on your right to *appeal* the adjudication of a claim.

Non-Assignment
The coverage, rights, privileges and benefits provided for under this *contract* are not assignable by you or anyone acting on your behalf. Any assignment or purported assignment of coverage, rights, privileges and benefits provided for under this *contract* that you may provide or execute in favor of

any *hospital, provider*, or any other person or entity shall be null and void and shall not impose any obligation on us.

Notwithstanding the foregoing, you may specifically authorize, in writing, the payment of benefits that we have determined to be due and payable directly to any *hospital, provider*, or other person who provided you with any *covered service* and we will honor this specific direction and make such payment directly to the designated provider of the *covered service*.

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.

Medicaid Reimbursement

The amount provided or payable under this *contract* will not be changed or limited for reason of a *member* being eligible for coverage under the Medicaid program of the state in which he or she lives. We will pay the benefits of this *contract* to the State if:

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

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

Custodial Parent

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

Upon request by the custodial parent, we will:

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

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

Physical Examination

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

Legal Actions

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

PRIOR TO INITIATING ANY ACTION AT LAW, YOU ARE ENCOURAGED TO FIRST COMPLETE ALL THE STEPS IN THE *COMPLAINT/GRIEVANCE/APPEAL* PROCEDURES MADE AVAILABLE TO RESOLVE DISPUTES IN FLORIDA UNDER THE *CONTRACT*. AFTER COMPLETING THAT *COMPLIANCE/GRIEVANCE/APPEALS* PROCEDURES PROCESS, IF YOU WANT TO BRING LEGAL ACTION AGAINST US ON THAT DISPUTE, YOU MUST DO SO WITHIN ONE YEAR OF THE DATE WE NOTIFIED YOU OF THE FINAL DECISION ON YOUR COMPLAINT/GRIEVANCE/APPEAL.

GRIEVANCE AND COMPLAINT PROCEDURES

Your satisfaction is very important to us. We want to know your issues and concerns so we can improve our services. Reporting these will not affect your healthcare services. The following processes are available to address your concerns:

Complaints

Complaints are the lowest form of a problem. It gives us the opportunity to resolve your problem without it becoming a formal *grievance*. Examples of a *complaint* include but not limited to, when you are unhappy with:

1. Care received from a provider.
2. Services received from a provider.
3. How long it takes to get an appointment.
4. How a *member* was treated
5. Services that is not included as an Ambetter from Sunshine Health benefit.
6. How a bill was paid
7. How you were treated by Ambetter from Sunshine Health staff

If you have a *complaint,* you may file your *complaint* in writing or by speaking with *Member* Services. *Complaints* are generally resolved within 72 hours following the receipt of the *complaint*. If you are not satisfied with the outcome of the *complaint*, you can request that your *compliant* be moved to a formal *grievance*. *Member* Services can assist you with instructions on how to file your grievance orally or in writing.

Grievances

A *grievance*, as referred to in this section, is a written *complaint* about anything other than an *adverse determination*. *Grievances* may refer to any dissatisfaction about:

1. Us, as the insurer, e.g., customer service *grievance*s - “the person to whom I spoke on the phone was rude to me”.
2. Providers with whom we have a direct or indirect *contract*.
   a. Lack of availability and/or accessibility of *network providers* not tied to an unresolved benefit denial; and
   b. Quality of care/quality of service issues.
3. Expressions of dissatisfaction regarding quality of care/quality of service.

Filing a *Grievance*

You have 365 calendar days from the date the issue occurred to file a *grievance* with us. You or your *authorized representative* may file a *grievance* by calling *Member* Services. At the time of your initial *complaint,* you will be informed that you have the right to file a written *grievance*. At your request, we will provide assistance to you in preparing the written *grievance*.

Written *grievances* may be sent to:

Ambetter from Sunshine Health
ATTN: Appeal Department
P.O. Box 459089
Fort Lauderdale, FL 33345-9089
Phone: 1-877-687-1169 or Relay FL 1-800-955-8770

Fax: 1-866-534-5972
Email: Sunshine_*Appeals*@centene.com

In your written *grievance*, please include:

1. Your first and last name
2. Your *member* identification number
3. Your address and telephone number
4. Details surrounding your concern
5. Any supporting documentation

Grievance Process and Resolution Timeframes

We will acknowledge your *grievance* by sending you a letter within five business days of receipt of your *grievance*.

*Grievance*s will be promptly investigated and will be resolved within 60 calendar days of receipt. The time period may be extended for an additional 30 calendar days, if we provide you or your *authorized representative*, if applicable, written notification of the following within the first 30 calendar days:

1. That we have not resolved the *grievance*.
2. When our resolution of the *grievance* may be expected; and
3. The reason why the additional time is needed.

If we do not receive the required information before the end of the extension period, we will resolve the *grievance* using the information we have on file.

Appeal

An appeal is a *grievance* involving a request to review, overturn, or otherwise modify an *adverse determination*. An *adverse determination* is coverage determination by us that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and coverage for the requested service is therefore denied, reduced, or terminated. You can *appeal* these decisions. You can also designate a representative –such as a family *member*, friend, *physician*, or attorney- to *appeal* these decisions on your behalf.

Filing an Appeal

When we make an *adverse determination*, we will send you a notification that includes information to file an *appeal* and how to designate an authorize a representative. You have 180 calendar days to file an *appeal* from the date we issue the *adverse determination*.

You can file an e*xpedited appeal* for a situation that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. Decisions regarding expedited *appeals* will be made as expeditiously as the *member's* health condition requires, but no later than 72 hours.

You can file an *appeal* by filling out the form included with the denial notice or sending a letter to:

Ambetter from Sunshine Health
ATTN: *Appeal* Department
P.O. Box 459089
Fort Lauderdale, FL 33345-9089
Phone: 1-877-687-1169 or Relay FL 1-800-955-8770
Fax: 1-866-534-5972
Email: Sunshine_*Appeal*s@centene.com

You can also file an *appeal* via phone by contacting us at 1-877-687-1169 or Relay FL 1-800-955-8770. Verbal request must be followed up in writing within 10 calendar days.

Call us at 1-877-687-1169 or Relay FL 1-800-955-8770 if you have any questions regarding the process or how to file an *appeal*. We will provide an interpreter service for you if you need them.

Appeal Process and Resolution Timeframes

After you file your *appeal*, we will notify you of all the information that is needed to process the *appeal* within 5 business days of receipt of the *appeal*. You will be informed that you can present any information that you wish for us to consider as part of the *appeal*. We will investigate the *appeal* to decide if more information is needed from you or your *provider*.

A reviewer of the same or similar specialty will review the request and make a determination. This reviewer will not be the *physician* involved in the original decision and who is not the subordinate of that *physician*.

We may extend our deadline by no more than 14 calendar days if we need additional information to reach a decision. We will inform you of the request's status if such an extension is necessary. If we do not receive the required information within the extended timeframe, we will make a determination based on the information we have. If no extension is needed, we will make the decision within 30 calendar days of receipt of your pre-service *appeal* or within 60 calendar days of receipt of your post-service *appeal.* We will notify you, your *provider,* and your authorized representative, if applicable, in writing within two business days of the decision.

The notice will include an explanation of our decision, a reference to the criteria on which the decision was based, a list of the title and qualifications of each person participating in the review, and a description of your further *appeal* rights. Your further *appeal* rights include the right to an External Review.

Expedited Appeal

An *expedited appeal* provides for evaluation by appropriate clinical peer or peers (who were not involved in the initial *adverse determination)* within 24 hours.

You can file an *expedited appeal* when a requested service involves a situation that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. This type of *appeal* must be documented with clinical information.

You or your authorized representative may file an *expedited appeal* in writing, or by calling *Member* Services. You may start the *appeal* process by phone or in writing. You may call *Member* Services to initiate an *expedited appeal* request.

We will make a decision about the request within 72 hours. We will notify you, your *provider*, and your *authorized representative*, if applicable, in writing within two business days once a decision has been made.

Written Grievance/Appeal Response

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

The written decision must include:

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

External Review

Our *member*s are offered two levels of *appeal* for *adverse determinations* related to a service that requires medical review. An external review decision is binding on us. An external review decision is binding on the claimant except to the extent the claimant has other remedies available under applicable federal or state law. We will pay for the costs of the external review performed by an independent reviewer.

Applicability/Eligibility

The external review procedures apply to any *hospital* or medical policy or certificate, excluding accident only or disability income only insurance.

External review is available for grievances that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered service; or the determination that a treatment is experimental or investigational, as determined by an external reviewer.
2. A determination of whether surprise billing protections apply and the member cost-sharing that applies for services subject to surprise billing protections; or
3. Rescissions of coverage.

After exhausting our internal review process, you can make a written request to the *Appeal*s & *Grievance* Department for an external review after the date of receipt of our internal response. We will send your request to an Independent Review Organization (IRO). You must contact the IRO or us within 120 calendar days of the date of your *appeal* resolution letter. If you do not file your *appeal* for an external independent review within 120 calendar days, it cannot be reviewed. If you are not sure whether your *appeal* is eligible, or if you want more information, please contact us.

To initiate an external *appeal*:

1. The internal *appeal* process must be exhausted before you may request an external review unless you file a request for an expedited external review at the same time as an internal *expedited appeal* or we either provide a waiver of this requirement or fail to follow the *appeal* process.
2. We must allow you to make a request for an expedited external review with us at the time you receive:
   a. An *adverse benefit determination* if the determination involves a medical condition of the claimant for which the timeframe for completion of an internal *expedited appeal* would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an internal *expedited appeal*.
   b. A final internal *adverse benefit determination*, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal *adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service for which you received *emergency* services, but has not been discharged from a facility.
3. You may request an expedited external review at the same time the internal *expedited appeal* is requested and an IRO will determine if the internal *expedited appeal* needs to be completed before proceeding with the expedited external review.

External Review Process

1. We have five (5) business days (immediately for expedited external review) following receipt of the request to conduct a preliminary review of the request to determine whether:
   a. The individual was a *covered person* at the time the item or service was requested.
   b. The service is a *covered service* under your health plan but for the plan's *adverse benefit determination* with regard to *medical necessity experimental or investigational,* medical judgment, or *rescission*.
   c. You have exhausted the internal process; and
   d. You have provided all of the information required to process an external review.
2. Within one (1) business day (immediately for expedited external review) after completion of the preliminary review, we will notify you in writing as to whether the request is complete but not eligible for external review and the reasons for its ineligibility or if the request is not complete, the additional information needed to make the request complete. We will include notification of your right to submit written testimony to be included in the materials sent to the IRO.
3. We must allow you to perfect the request for external review within the four (4)-month filing period or within the 48-hour period following the receipt of notification.
4. We will assign an IRO on a rotating basis from our list of contracted IROs.
5. Within five (5) business days after the date of assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO.
   NOTE: For expedited external review, after assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method.
6. If we fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the *adverse benefit determination*.
7. Within 10 business days, the assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that you may submit in writing additional information to the IRO to consider.
8. Upon receipt of any information submitted by you, the IRO must forward the information to us within one (1) business day.
9. Upon receipt of the information, we may reconsider our determination. If we reverse our *adverse benefit determination*, we must provide written notice of the decision to you and the IRO within one (1) business day after making such decision. The external review would be considered terminated.
10. Within 45 calendar days (72 hours for expedited external review) after the date of receipt of the request for an external review by the health plan, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to you and to us. If the notice for an expedited external review is not in writing, the IRO must provide written confirmation within 48 hours after the date of providing the notice.
11. Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, we will approve the covered benefit that was the subject of the *adverse benefit determination*.

After you receive a decision from us concerning your benefits and feel further action is needed, you have the right to file a *complaint* with the Department of Financial Services, Division of Consumer Services.

You may request assistance of the Department of Financial Services, Division of Consumer Services by telephone at 1-877-MY-FL-CFO (1-877-693-5236), or if calling from outside of Florida (1-850-413-3089), by email at ConsumerServices@myfloridacfo.com, or online at: http://www.myfloridacfo.com/Division/Consumers/

You, or someone you *authorized* to do so, shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. All comments, documents, records and other information submitted by you relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal *appeal*.

*Appeal*s and *Grievance*s filing and key communication timelines

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard *Grievance*	365 Calendar Days	5 Business Days	60 Calendar Days	30 Calendar Days
Urgent Grievance	365 Calendar Days	N/A	72 hours	N/A
Standard Pre-Service *Appeal*	180 Calendar Days	5 Business Days	30 Calendar Days	14 Calendar Days
Expedited Pre-Service *Appeal*	180 Calendar Days	N/A	72 hours	N/A
Standard Post-Service *Appeal*	180 Calendar Days	5 Business Days	60 Calendar Days	14 Calendar Days
External Review	4 Months	6 Business Days	45 Calendar Days	N/A
Expedited External Review	4 Months	Immediately	72 hours	N/A

GENERAL PROVISIONS

Entire Contract

This *contract*, with the application and any rider-amendments is the entire *contract* between you and us. No party or agent of a party may:

1. Change or alter the terms of this *contract*.
2. Waive any provision of this *contract*.
3. Extend the time for payment of premiums.
4. Waive any of our rights or requirements under the *contract*; or
5. Waive any of your obligations under the *contract*.

Non-Waiver

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

Rescissions

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

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

We will provide the *member* 45 calendar days advance written notice before coverage is rescinded.

Time Limit on Certain Defenses

Relative to a misstatement in the application, after two years from the issue date, only fraudulent misstatements in the application may be used to void the *contract* or deny any claim for *loss* incurred or disability starting after the two year period.

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 the *contract*. We will return any premium paid during the time period for which the *member* returned benefit payments.

Conformity with State Laws

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

Construction
We have the full power, authority, and discretion to construe and interpret any and all provisions of this *contract* to the greatest extent allowed by applicable law.

Performance Outcomes and Financial Data
You may obtain information regarding performance outcomes and financial data for Celtic Insurance Company published by the State of Florida Agency for Health Care Administration by accessing Ambetter from Sunshine Health's website: Ambetter.SunshineHealth.com. This website includes the link to Florida Health State where this information is published.

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 sunshinehealth.com/privacy-practices.html or call *Member* Services.

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

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

Statement of Non-Discrimination

Ambetter from Sunshine Health is underwritten by Celtic Insurance Company, which is a Qualified Health Plan issuer in the Florida Health Insurance Marketplace. Celtic Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, or sex characteristics). This is a solicitation for insurance. © 2023 Celtic Insurance Company. All rights reserved. Ambetter.SunshineHealth.com

If you, or someone you are helping, have questions about Ambetter from Sunshine Health, and are not proficient in English, you have the right to get help and information in your language at no cost and in a timely manner. If you, or someone you are helping, have an auditory and/or visual condition that impedes communication, you have the right to receive auxiliary aids and services at no cost and in a timely manner. To receive translation or auxiliary services, please contact Member Services at 1-877-687-1169 (Relay Florida 1-800-955-8770). If you believe that Celtic Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, or sex characteristics), please contact Member Services at 1-877-687-1169 (Relay Florida 1-800-955-8770). You may also submit a grievance by phone to 1-877-687-1169 (Relay Florida 1-800-955-8770). For information on filing a discrimination complaint directly with the U.S. Department of Health and Human Services, Office of Civil Rights, please visit https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf.

Declaración de No Discriminación

Ambetter from Sunshine Health está suscrito por Celtic Insurance Company, que es un proveedor Calificado de Planes de Salud en el Mercado de Seguros de Salud de Florida. Celtic Insurance Company cumple con las leyes de derechos civiles Federales aplicables y no discrimina por motivos de raza, color de piel, nacionalidad de origen (incluidos un nivel de inglés limitado y la lengua materna), edad, discapacidad o sexo (incluidos el embarazo, la orientación sexual, la identidad de género o las características sexuales). Esta es una solicitud de seguro. © 2023 Celtic Insurance Company. Todos los derechos reservados. Ambetter.SunshineHealth.com

Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Sunshine Health y no domina el inglés, tiene derecho a obtener ayuda e información en su idioma sin costo alguno y de manera oportuna. Si usted, o alguien a quien está ayudando, tiene un impedimento auditivo y/o visual que le dificulta la comunicación, tiene derecho a recibir ayuda y servicios auxiliares sin costo alguno y de manera oportuna. Para recibir servicios auxiliares o de traducción, comuníquese con Servicios para Miembros al 1-877-687-1169 (Servicio de Retransmisión de Florida: 1-800-955-8770). Si considera que Celtic Insurance Company no le proporcionó estos servicios o lo discriminó de otra manera por motivos de raza, color de piel, nacionalidad de origen (incluidos un nivel de inglés limitado y la lengua materna), edad, discapacidad o sexo (incluidos el embarazo, la orientación sexual, la identidad de género o las características sexuales), comuníquese con Servicios para Miembros al 1-877-687-1169
(Servicio de Retransmisión de Florida: 1-800-955-8770). También puede presentar una queja por teléfono al 1-877-687-1169 (Retransmisión de Florida: 1-800-955-8770). Para obtener información sobre cómo presentar una queja por discriminación directamente ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU., visite https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf.

English:	If you, or someone you are helping, have questions about Ambetter from Sunshine Health, and are not proficient in English, you have the right to get help and information in your language at no cost and in a timely manner. If you, or someone you are helping, have an auditory and/or visual condition that impedes communication, you have the right to receive auxiliary aids and services at no cost and in a timely manner. To receive translation or auxiliary services, please contact Member Services at 1-877-687-1169 (Relay Florida 1-800-955-8770).
Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Sunshine Health y no domina el inglés, tiene derecho a obtener ayuda e información en su idioma sin costo alguno y de manera oportuna. Si usted, o alguien a quien está ayudando, tiene un impedimento auditivo o visual que le dificulta la comunicación, tiene derecho a recibir ayuda y servicios auxiliares sin costo alguno y de manera oportuna. Para recibir servicios auxiliares o de traducción, comuníquese con Servicios para Miembros al 1-877-687-1169 (Relay Florida 1-800-955-8770).
French Creole:	Si ou menm, oswa yon moun w ap ede, gen kesyon sou Ambetter from Sunshine Health, epi nou pa mètrize Anglè, nou gen dwa pou jwenn èd ak enfòmasyon nan lang nou gratis epi nan moman ki apwopriye a. Si ou menm, oswa yon moun w ap ede, gen yon pwoblèm pou tande ak/oswa yon pwoblèm pou wè ki pètibe kominikasyon nou, nou gen dwa pou resevwa asistans ak sèvis oksilyè gratis epi nan moman ki apwopriye a. Pou resevwa sèvis tradiksyon oswa sèvis oksilyè yo, tanpri kontakte Sèvis Manm yo nan 1-877-687-1169 (Relay Florida 1-800-955-8770).
Vietnamese:	Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter from Sunshine Health và không thành thạo tiếng Anh, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí và kịp thời. Nếu quý vị hoặc người mà quý vị đang giúp đỡ mắc bệnh về thính giác và/hoặc thị giác gây cản trở giao tiếp, quý vị có quyền được nhận các hỗ trợ và dịch vụ phụ trợ miễn phí và kịp thời. Để nhận dịch vụ thông dịch hoặc dịch vụ phụ trợ, vui lòng liên hệ bộ phận Dịch Vụ Thành Viên theo số 1-877-687-1169 (Relay Florida 1-800-955-8770).
Portuguese:	Se tiver dúvidas acerca da Ambetter from Sunshine Health, ou estiver a ajudar uma pessoa com dúvidas acerca desta, e não dominar o inglês, tem o direito de obter ajuda e informações no seu idioma sem qualquer custo e de forma atempada. Se tiver uma condição visual e/ou auditiva que dificulte a comunicação ou estiver a ajudar uma pessoa com uma condição deste tipo, tem o direito de receber equipamentos ou serviços de assistência sem qualquer custo e de forma atempada. Para receber traduções ou serviços de assistência, contacte serviços de membro através do número 1-877-687-1169 (Relay Florida 1-800-955-8770).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Sunshine Health 方面的問題，且不精通英語，您有權利免費並及時以您的母語獲幫助和訊息。如果您，或您正在協助的對象有聽力和/或視力上的問題，阻礙了溝通，您有權利免費並及時獲得輔助支援與服務。若要取得翻譯或輔助服務，請聯絡會員服務部，電話是 1-877-687-1169 (Relay Florida 1-800-955-8770)。
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Sunshine Health et que vous ne maîtrisez pas l'anglais, vous pouvez bénéficier gratuitement et en temps utile d'aide et d'informations dans votre langue. Si vous-même ou une personne que vous aidez souffrez d'un trouble auditif ou visuel qui entrave la communication, vous pouvez bénéficier gratuitement et en temps utile d'aides et de services auxiliaires. Pour profiter de services de traduction ou de services auxiliaires, veuillez contacter Services aux membres au 1-877-687-1169 (Relay Florida 1-800-955-8770).
Tagalog:	Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter from Sunshine Health, at hindi ka mahusay sa Ingles, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos at sa maagap na paraan. Kung ikaw, o ang iyong tinutulungan, ay may kondisyon sa pandinig at/o paningin na nakakaapekto sa komunikasyon, may karapatan kang makatanggap ng mga karagdagang tulong at serbisyo nang walang gastos at sa maagap na paraan. Para makatanggap ng mga serbisyo sa pagsasalin o mga karagdagang serbisyo, mangyaring makipag-ugnayan sa Mga Serbisyo para sa Miyembro sa 1-877-687-1169 (Relay Florida 1-800-955-8770).
Russian:	Если у вас или у лица, которому вы помогаете, возникли какие-либо вопросы о программе страхования Ambetter from Sunshine Health, при этом вы недостаточно хорошо владеете английским языком, вы имеете право на бесплатную и своевременную помощь и информацию на своем родном языке. Если у вас или у лица, которому вы помогаете, наблюдается какое-либо нарушение слуха и/или зрения, которое препятствует коммуникации, вы имеете право на бесплатные и своевременные вспомогательные услуги и помощь. Для получения услуг перевода или вспомогательных услуг обратитесь в отдел обслуживания участников программы страхования по номеру 1-877-687-1169 (Relay Florida 1-800-955-8770).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Sunshine Health، ولم تكن بارعًا باللغة الإنكليزية، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت أنت أو أي شخص تساعده تعاني من حالة سمعية و/أو بصرية تعيق التواصل، فلديك الحق في تلقي مساعدات وخدمات إضافية من دون أي تكلفة وفي الوقت المناسب. لتلقي خدمات الترجمة أو خدمات إضافية، يرجى الاتصال بـ خدمات الأعضاء على 1-877-687-1169 (Relay Florida 1-800-955-8770).
Italian:	Se Lei o una persona a cui sta fornendo assistenza ha domande su Ambetter from Sunshine Health e non ha una perfetta padronanza della lingua inglese, ha il diritto di ricevere aiuto e informazioni nella Sua lingua gratuitamente e tempestivamente. Se Lei o una persona a cui sta fornendo assistenza presenta una condizione uditiva e/o visiva che impedisce la comunicazione, ha il diritto di ricevere servizi ausiliari gratuitamente e tempestivamente. Per ricevere una traduzione o un servizio ausiliario, contatti i Servizi per i membri al numero 1-877-687-1169 (Relay Florida 1-800-955-8770).

German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Sunshine Health hat und nicht Englisch spricht, haben Sie das Recht, kostenlos und zeitnah Hilfe und Informationen in Ihrer Sprache zu erhalten. Falls Sie oder jemand, dem Sie helfen, eine Hör- und/oder Sehbeeinträchtigung hat, die die Kommunikation beeinflusst, haben Sie das Recht, kostenlos und zeitnah zusätzliche Hilfe und Dienstleistungen zu erhalten. Um eine Übersetzung oder zusätzliche Dienstleistungen zu erhalten, wenden Sie sich an den Kundendienst unter 1-877-687-1169 (Relay Florida 1-800-955-8770).
Korean:	귀하 또는 귀하의 도움을 받는 분이 Ambetter from Sunshine Health에 대한 질문이 있는 경우 영어에 능숙하지 않으시면 해당 언어로 시의적절하게 무료 지원과 정보를 받을 권리가 있습니다. 귀하 또는 귀하의 도움을 받는 분이 청각 및/또는 시각적으로 의사소통에 장애가 있는 경우 시의적절하게 무료 보조 도구 및 서비스를 받을 권리가 있습니다. 번역 또는 보조 서비스를 받으시려면 1-877-687-1169(Relay Florida 1-800-955-8770)번으로 가입자 서비스부에 연락해주십시오.
Polish:	Jeśli Ty lub osoba, której pomagasz, macie pytania dotyczące Ambetter from Sunshine Health, ale nie posługujecie się biegle językiem angielskim, macie prawo do uzyskania pomocy i informacji w swoim języku bez dodatkowych kosztów i w odpowiednim czasie. Jeśli Ty lub osoba, której pomagasz, macie problemy ze słuchem i/lub wzrokiem, które utrudniają komunikację, macie prawo do otrzymania pomocy i usług pomocniczych bez dodatkowych kosztów i w odpowiednim czasie. Aby uzyskać tłumaczenie lub usługi pomocnicze, należy skontaktować się z Usługi członkowskie pod numerem 1-877-687-1169 (Relay Florida 1-800-955-8770).
Gujarati:	જો તમને અથવા તમે જેમની મદદ કરી રહ્યા હો એવી કોઈ વ્યક્તિને Ambetter from Sunshine Health વિશે પ્રશ્નો હોય અને અંગ્રેજીમાં પ્રવીણ ન હોય, તો તમને કોઈ ખર્ચ કર્યા વિના અને સમયસર તમારી ભાષામાં મદદ તથા માહિતી મેળવવાનો અધિકાર છે. જો તમે અથવા તમે જેમની મદદ કરી રહ્યા હો એવી કોઈ વ્યક્તિ શ્રવણશક્તિ અને/અથવા દૃષ્ટિવિષયક અવસ્થાથી પીડિત હોય કે જે સંચારને અવરોધતી હોય, તો તમને કોઈ ખર્ચ કર્યા વિના અને સમયસર સહાયક સહાય તથા સેવાઓ પ્રાપ્ત કરવાનો અધિકાર છે. અનુવાદ અથવા સહાયક સેવાઓ પ્રાપ્ત કરવા માટે, કૃપા કરીને 1-877-687-1169 (Relay Florida 1-800-955-8770) પર સભ્યની સેવાઓનો સંપર્ક કરો.
Thai:	หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีคำถามเกี่ยวกับ Ambetter from Sunshine Health และไม่ชำนาญในการใช้ภาษาอังกฤษ คุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและข้อมูลในภาษาของคุณโดยไม่เสียค่าใช้จ่ายอย่างทันท่วงที หากคุณหรือคนที่คุณกำลังให้ความช่วยเหลือมีภาวะด้านการฟังและ/หรือการมองเห็นที่เป็นอุปสรรคต่อการสื่อสาร คุณมีสิทธิ์ที่จะขอรับความช่วยเหลือและบริการเสริมโดยไม่เสียค่าใช้จ่ายอย่างทันท่วงที หากต้องการบริการด้านการแปลหรือบริการเสริม โปรดติดต่อ บริการสำหรับสมาชิก ที่หมายเลข 1-877-687-1169 (Relay Florida 1-800-955-8770)