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2024 Evidence of Coverage

Ambetter.LouisianaHealthConnect.com

Ambetter from Louisiana Healthcare Connections

Home Office : P.O. Box 84180, Baton Rouge, LA 70884

Major Medical Expense Insurance Policy

In this *policy,* the terms *"*you*"* or *"*your*"* will refer to the *member* or any *dependents* named on the *Schedule of Benefits*. The terms *"*we*," "*our*,"* or *"*us*"* will refer to **Louisiana Healthcare Connections** or **Ambetter from Louisiana Healthcare Connections**.

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

Guaranteed renewable means that this *policy* will renew each year on the anniversary date unless terminated earlier in accordance with *policy* terms. You may keep this *policy* in force by timely payment of the required premiums. However, we may decide not to renew the *policy* as of the renewal date if: (1) we decide not to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where you then live; or (2) we withdraw from the *service area*; or (3) there is fraud, or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *policy* benefits.

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

At least 60 calendar days' notice of any plan to take an action or make a change permitted by this clause will be delivered to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under this *policy* or a change in a *member's* health. While this *policy* is in force, we will not restrict coverage already in force. If we discontinue offering and decide not to renew all polices issued on this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 90 calendar days prior to the date that we discontinue coverage.

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

This policy takes effect at 12:01 a.m. of the date on which the *member*'s coverage begins and terminates at 11:59 pm on the last day of the month for which premiums were paid and the date that the *member*'s coverage ends.

NOTICE: HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A *NETWORK* HEALTH CARE FACILITY BY FACILITY-BASED *PHYSICIANS* WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE *NON-NETWORK* SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR *COPAYMENTS*, COINSURANCE, *DEDUCTIBLES*, AND NON-COVERED SERVICES. SPECIFIC INFORMATION ABOUT *NETWORK* AND *NON-NETWORK* FACILITY-BASED *PHYSICIANS* CAN BE FOUND AT OUR WEBSITE AMBETTER.LOUISIANAHEALTHCONNECT.COM OR CALLING THE CUSTOMER SERVICE NUMBER OF THE HEALTH PLAN.

NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

TEN DAY RIGHT TO RETURN POLICY

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

Ambetter Health of Louisiana

Jamie Schlottman
CEO and Plan President

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INTRODUCTION

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

It describes:

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

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

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

How to Contact Us

Ambetter from Louisiana Healthcare Connections
P.O. Box 84180
Baton Rouge, LA 70884

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

Member Services	1-833-635-0450
TTY line	711
Fax	1-877-941-8073
Emergency	**911**

24/7 Nurse Advice Line 1-833-635-0450 or for the hard of hearing (TTY 711)

Interpreter Services

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

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

To arrange for interpreter services, please call Member Services.

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

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

You have the right to:

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

9. Voice *complaints* or *grievances* about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
10. See your medical records.
11. Be kept informed of *covered* and non-covered services, program changes, how to access services, *PCP* assignment, providers, advance directive information, referrals and *authorizations*, benefit denials, *member* rights and responsibilities, and our other rules and guidelines. We will notify you at least 60 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*.
13. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
14. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, ethnicity, race, religion, gender, sexual orientation, national origin, physical or mental disability or expected health or genetic status.
15. Access *medically necessary* urgent and *emergency* services 24 hours a day, seven days a week.
16. Receive information in a different format in compliance with the Americans with Disabilities Act if you have a disability.
17. Refuse treatment to the extent the law allows without jeopardizing future treatment and be informed by your provider(s) of the medical consequences. You are responsible for your actions if treatment is refused or if the *physician*'s instructions are not followed. You should discuss all concerns about treatment with your *physician*. Your *physician* can discuss different treatment plans with you, if there is more than one option that may help you. You will make the final decision.
18. Select your *PCP* within the *network*. You also have the right to change your *PCP* or request information on *network providers* close to your home or work.
19. Know the name and job title of people giving you care. You also have the right to know which *physician* is your *PCP*.
20. An interpreter when you do not speak or understand the language of the area.
21. A second opinion by a *network physician* if you believe your *network provider* is not authorizing the requested care, or if you want more information about your treatment.
22. Make advance directives for health care decisions. This includes planning treatment before you need it.
23. Determine what actions should be taken regarding your health if you are no longer able to make decisions for yourself because of *illness* or because you are incapacitated. You have the right to have your wishes known by completing Advance directive forms. Advance directive forms are forms you can complete to protect your rights for medical care. It can help your *PCP* and other providers understand your wishes about your health. Advance directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself. Examples of advance directives include:
    a. Living Will;
    b. Health Care Power of Attorney; or
    c. "Do Not Resuscitate" Orders. *Members* also have the right to refuse to make advance directives. You should not be discriminated against for not having an

advance directive.

You have the responsibility to:

1. Read this *policy* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about your health that we or your *medical practitioners* need in order to provide care. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your *physician* until you understand the care you are receiving.
4. Review and understand the information you receive about us. You need to know the proper use of *covered services*.
5. Show your *member* identification card and keep scheduled appointments with your *physician* and call the *physician's* office during office hours whenever possible if you have a delay or cancellation.
6. Know the name of your assigned *PCP*. You should establish a relationship with your *physician*. You may change your *PCP* verbally or in writing by contacting Member Services.
7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
8. Follow the treatment plans and instructions for care that you have agreed on with your health care professionals and *physician*.
9. Tell your health care professional and *physician* if you do not understand your treatment plan or what is expected of you. You should work with your *PCP* to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.
10. Follow all health benefit plan guidelines, provisions, policies, and procedures.
11. Use any emergency room only when you think you have a medical *emergency*. For all other care, you should call your *PCP*.
12. When you enroll in this coverage, give all information about any other medical coverage you have. If, at any time, you get other medical coverage besides this coverage, you must tell us.
13. Pay your monthly premiums, *deductible amount*, *copayment amounts,* and *coinsurance amounts* on time.
14. Notify us or the entity you enrolled with of any enrollment related changes that would affect your *policy* within 60 calendar days of the event. Enrollment related changes include the following: birth of a child, adoption, marriage, divorce, adding/removing a dependent, *spouse*/domestic partner becomes eligible under a different insurer, change of address or incarceration where *member cost share* would need to transfer from one policy to another policy.

IMPORTANT INFORMATION

Provider Directory

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

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

Call the *PCP*'s office if you want to make an appointment. If you need help, call Member Services at. 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 material and you have paid your initial premium payment. This card is proof that you are enrolled in the Ambetter plan. You need to keep this card with you at all times. Please show this card every time you go for any service under the *policy*. The *member* identification card will show your name, *member* identification number, the phone numbers for Member Services, pharmacy and 24/7 Nurse Advice Line and *copayment amounts* required at the time of service. Any applicable deductibles, and any applicable out-of-pocket maximum limitations will also be accessible through the member identification card. 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.LouisianaHealthConnect.com.

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.

Website

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

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

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

Quality Improvement

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

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

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

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

Protection from Balance Billing

Under Federal law, effective January 1, 2022, *non-network providers* or facilities are prohibited

from *balance billing* health plan *members* for services that are subject to *balance billing* protections as described in the Definitions section of this *policy*. 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 *policy*, italicized words are defined. Words not italicized will be given their ordinary meaning.

Wherever used in this *policy*:

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

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

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

Adverse determination means:

1. A determination by the plan, based upon the information provided, a request for a benefit under the plan upon application of any utilization review technique that does not meet the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.
2. The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by the plan of a member's eligibility to participate in the plan.
3. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit under the plan.
4. A rescission of coverage determination.

As it relates to the balance billing protections under the federal No Surprises Act, adverse determination means:

5. An incorrectly calculated amount of cost sharing a member owes when balance billing protections apply.

6. A determination that balance billing protections do not apply to a service.

Allowed amount (also see **"*Eligible expense"***) means the maximum amount we will pay a provider for a *covered service*. When a *covered service* is received from a *network provider*, the *allowed amount* is the amount the provider agreed to accept from us as payment for that particular service. In all cases, the *allowed amount* will be subject to *cost sharing* (e.g., *deductible*, *coinsurance,* and *copayment*) per the ***member's*** benefits. This amount excludes 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 *allowed 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 *policy*. 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 request to reconsider a decision about the ***member's*** benefits where either a service or claim has been denied.

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

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

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

Authorized representative means any of the following:

1. A person to whom a covered person has given express written consent to represent the covered person. It may also include the covered person's treating provider if the covered person appoints the provider as his authorized representative and the provider waives in writing any right to payment from the covered person other than any applicable copayment or other coinsurance amount. In the event that the service is determined not to be medically necessary, and the covered person or his authorized representatives, except for the covered person's treating health care professional, thereafter, requests the services, nothing shall prohibit the provider from charging usual

and customary charges for all non-medically necessary services provided.
2. A person authorized by law to provide substituted consent for a covered person.
3. An immediate family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent.
4. In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

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

Balance billing means a *non-network provider* billing you for the difference between the *provider's* charge for a service and the *eligible expense*. *Network providers* may not balance bill you for *covered 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 means both *mental health disorders* and *substance use disorders*, encompassing a continuum of prevention, intervention, treatment, and recovery support services.

Beneficiary means a person designated by a participant, or by the terms of a health insurance benefit plan, who is or may become entitled to a benefit under the plan.

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

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

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

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

Center of Excellence means a *hospital* that:

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

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

Cleft lip and cleft palate service means preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.

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

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

Complications of pregnancy means:

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

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

undergoing a course of institutional or *inpatient* care from that provider or facility; (iii) is scheduled to undergo non-elective *surgery* from that provider, including postoperative care; (iv) is pregnant and undergoing a course of treatment for the *pregnancy*; or (v) is or was determined to be *terminally ill* and is receiving treatment for such *illness*.

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

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

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

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

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

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

Credible coverage means coverage of an individual under (a) A group health plan; (b) Health insurance coverage; (c) Medicare coverage; (d) Medicaid; (e) Medical Insurance coverage under the General Military Law; (f) A medical care program of the Indian Health Service of a tribal organization; (g) A state health benefits risk pool; (h) A health plan offered for federal employees; (i) A public health plan; or (j) A health benefit plan provided to members of the Peace Corps. Such term does not include coverage consisting solely of coverage of excepted benefits.

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

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

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

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

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

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

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

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

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

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

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

Eligible child means the child of a primary subscriber if that child is less than 26 years of age. If an eligible child turns 26 during the plan year, they remain an eligible child through the end of the plan year. As used in this definition, "child" means:
1. A natural child;
2. A legally adopted child;
3. A child placed with you for adoption;
4. A foster child placed in your custody;

5. A child for whom legal guardianship has been awarded to you, your *spouse,* or your domestic partner;
6. A stepchild;
7. A grandchild residing with you, provided you have been granted legal custody or provisional custody by mandate of the grandchild; or
8. An unmarried child who is placed in the home of an insured following execution of an act of voluntary surrender in favor of you or your legal representative, for whom the date after which the act of voluntary surrender becomes irrevocable has passed.

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

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

1. For *network providers*: When a *covered service* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.
2. For *non-network providers*, unless otherwise required by Federal or Louisiana law, the *eligible expense* is as follows:
    a. When *balance billing protections* apply to a *covered service* received from a *non-network provider*, the eligible expense is the negotiated fee, if any, that has been mutually agreed upon by us and the *provider* as payment in full. If the provider has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by applicable law, the eligible expense is reimbursement as determined by us and as required by applicable law.
    b. For all other *covered services* received from a *non-network provider* for which any needed *authorization* is received from 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 *balanced 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 *policy*. 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 *policy*. 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 has been created for you. You can access your consumer dashboard at *enroll.ambetterhealth.com*.

Enrollee means an individual who is enrolled in a health maintenance organization.

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

1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the claimant or the ability of the claimant to regain maximum function.
2. In the opinion of a *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 grievance*.

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

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

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

Items (3) and (4) above do not apply to phase III or IV FDA clinical trials. Benefits are available for routine care costs that are incurred in the course of a clinical trial if the services provided are otherwise *covered services* under this *policy*.

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

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

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

Final adverse determination means an *adverse determination*, including medical judgment, involving a *covered service* that has been upheld by a health insurance issuer, or its designee *utilization review* organization, at the completion of the health insurance issuer's internal claims and *appeals* process procedures provided pursuant to R.S. 22:2401.

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

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

Grievance means, in a health insurance issuer's internal claims and *appeals* process, a written *complaint* or oral *complaint*, if the *complaint* involves an urgent care request submitted by or on behalf of a *covered person* regarding any of the following:

1. *Availability*, delivery, or quality of health care services, including a *complaint* regarding an *adverse determination* made pursuant to *utilization review*.

2. Claims payment, handling, or reimbursement for health care services.
3. Matters pertaining to the contractual relationship between a covered person and a health insurance issuer.

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

Home health aide service 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 place for the aged, drug addicts, alcoholics, or runaways; a facility for wilderness or outdoor programs; or a similar establishment.

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

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

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

Immediately means as expeditiously as the medical situation of the *covered person* requires but in no event longer than one day for expedited reviews or one business day for standard reviews.

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.

Life-threatening illness means a severe, serious, or acute condition for which death is probable.

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

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

Maximum out-of-pocket amount means the 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 a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification. Additional healthcare providers include:

1. Certified or registered addiction counselors;
2. Licensed, certified, or registered prevention professionals;
3. Certified compulsive gambling counselors;
4. Behavioral health provider;
5. Providers who work for licensed agencies; or
6. Credentialed providers which provide community psychiatric support and treatment services or psychosocial rehabilitation services.

Medically necessary means our decision as to whether any medical service, item, supply, or treatment to diagnose and treat a member's *illness* or *injury*:

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

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

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

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

Necessary medical supplies mean medical supplies that are:

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

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

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

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

Network provider means any licensed person or entity that has entered into a contract directly or indirectly with Ambetter from Louisiana Healthcare Connections to provide *covered services* to *members* enrolled under this *policy* including but not limited to, *hospitals*, specialty *hospitals*, Urgent Care facilities, *physicians*, pharmacies, laboratories, and other health professionals.

Newly born means infants from the time of birth until age one month or until such time as the infant is well enough to be discharged from a *hospital* or neonatal special care unit to his home, whichever period is longer.

Non-elective cesarean section means:
1. A cesarean section where vaginal delivery is not a medically viable option; or
2. A repeat cesarean section.

Non-network provider means a *medical practitioner, provider facility,* or other *provider* who is NOT a *network provider*. Services received from a *non-network provider* are not *covered*, except:
1. *Emergency services*, as described in the Major Medical Expense Benefits section of this *policy*;
2. Non-emergency health care services received at a *network* facility, as described in the Access to Care section of this *policy*;
3. Air ambulance services; and
4. Situations otherwise specifically described in this *policy*.

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 non-medical transportation or non-emergency 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* custom fabricated brace or support that is designed as a component of a *prosthetic device*.

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

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

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

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

Placement or ***being placed***, for adoption, in connection with any *placement* for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's *placement* with such person terminates upon the termination of such legal obligation.

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

Policy year means the 12-month *calendar year* beginning at 12:00 a.m. on January 1 and ending at 11:59 p.m. on December 31.

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 *approval* by us in advance of the claimant obtaining the medical care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Rehabilitation licensed practitioner means, but is not limited to, a *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 coverage means a cancellation or discontinuance of coverage that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:

1. The cancellation or discontinuance of coverage has only a prospective effect; or
2. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

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

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

1. Is not a *hospital, extended care facility,* or *rehabilitation facility*; or

2. Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

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

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

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

Serious acute condition means a disease or condition requiring complex ongoing care which the *Member* is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits.

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

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

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

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

Spouse means your lawful wife or husband.

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).

Subscriber means the primary individual who applied for this coverage and who is responsible for payment to a health maintenance organization or whose employment or other status, except for family dependence, is the basis for eligibility for enrollment in the health maintenance organization.

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 (including physical therapy) 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.

Temporarily medically disabled mother means a woman who has recently given birth and whose *physician* has advised that normal travel would be hazardous to her health.

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

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

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

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

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

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

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

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

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

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

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 insurance on the latter of:

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

Effective Date for Initial Dependent Members

Dependent members included in the initial enrollment application for this *policy* will be covered on your *effective date*.

Dependent Medical Leave of Absence

Coverage will continue for a *dependent member* college student who takes a medical leave of absence or reduces his or her course load to part-time status because of a catastrophic *illness* or *injury*. Continuation of coverage for such a *dependent member* college student will automatically terminate 12 months after notice of the *illness* or *injury* or until coverage would have otherwise lapsed pursuant to the terms and conditions of this *policy*, whichever comes first, provided the need for part-time status or medical leave of absence is supported by a clinical certification of need from a *physician* licensed to practice medicine in all its branches.

Coverage for a Newborn Child

An *eligible child* born to you, or a covered family member *will* be covered from the time of birth until the 31st day after its birth, unless we have received notice otherwise. Each type of *covered service* incurred by the newborn child will be subject to the *cost sharing* amount listed in the *Schedule of Benefits*.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth. The required premium will be calculated from the child's date of birth. If notice of the newborn is given to us by the Health Insurance Marketplace within the 31 calendar days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 calendar days after the birth of the child. If notice is not given within the 31 calendar days from birth, we will charge an additional premium from the date of birth. If notice is given by the Health Insurance Marketplace within 60 calendar days of the birth of the child, we may not deny coverage of the child due to failure to notify us of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st day after its birth unless we have received notice by the Health Insurance Marketplace of the child's birth.

Coverage for an Adopted Child

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

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

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child and we have received notification from the 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 calendar days of the birth or *placement* and b) any additional premium required for the addition of the child within 90 calendar 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.

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

ONGOING ELIGIBILITY

For All Members

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

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

If you have material modifications (examples include a change in life event such as marriage, death, or other change in family status), or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Marketplace) at www.healthcare.gov or 1-800-318-2596. If you enrolled through Ambetter, you can 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 *eligible children*, the coverage will terminate the thirty-first day of December the year the dependent turns 26 years of age.

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

1. 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.

You must furnish us with periodic proof of continuing incapacity and dependency within 31 calendar days of the child's 26th birthday. We may require subsequent proof once a year after the initial two-year period following the child's 26th birthday.

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.

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 individuals* may be granted a Special Enrollment Period where they may enroll in or change to a different Marketplace plan during the current plan year if they have a qualifying event. Qualifying events include:

1. A *qualified individual* or *dependent* experiences a loss of *minimum essential coverage,* non-*calendar year* group or A *qualified individual* or *dependent loses minimum essential coverage*, non-*calendar year* group or individual health insurance coverage, pregnancy-related coverage, access to health care services through coverage provided to a pregnant *enrollee's* unborn child, or medically needed coverage;
2. A *qualified individual* gains a *dependent* or becomes a *dependent* through marriage, birth, adoption, *placement* for adoption, *placement* in foster care, or a child support order or other court order. In the case of marriage, at least one *spouse* must demonstrate having *minimum essential coverage* as described in 26 CFR 1.5000A-1(b) for 1 or more calendar 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 *policy* in relation to the *enrollee*;
6. A *qualified individual*, *enrollee*, or *dependent*, adequately demonstrates to the Health Insurance Marketplace that a material error related to plan benefits, *service area*, or premium influenced the *qualified individual's* or *enrollee's* decision to purchase the *QHP*;
7. An *enrollee* or *dependent* enrolled in the same plan is determined newly eligible or newly ineligible for *advance premium tax credits* or has a change in *eligibility* for *cost sharing reductions*;
8. A *qualified individual* or *dependent* who is enrolled in an eligible employer-sponsored plan is determined newly eligible for *advance premium tax credits* based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-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 calendar 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 HHS to verify his or her citizenship, status as a national, or lawful presence;
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; or
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 health care eligibility and enrollment decisions for *members* who enrolled via the Marketplace.

If you are currently enrolled in Ambetter from Louisiana Healthcare Connections, 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. A *subscriber* may enroll an unborn natural child prior to birth; however, coverage will not be effective until the date of birth.

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

If a *qualified individual*, *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.

Prior Coverage

If a *member* is confined as an *inpatient* in a *hospital* on the *effective date* of this *policy* and prior coverage is terminating *immediately* before the *effective date* of this *policy* furnishes benefits for the hospitalization after the termination of prior coverage, then services and benefits will not be covered under this *policy* for that *member* until the *member* is discharged from the *hospital* or benefits under the prior coverage are exhausted, whichever is earlier.

If there is no prior coverage or no continuation of *inpatient* services after the *effective date*, your coverage will apply for *covered services* related to the *inpatient* services after your *effective date*. Your coverage requires you to notify us within two calendar days of your

effective date or as soon as reasonably possible so we can review and *authorize medically necessary* services. If services are at a non-contracted *hospital*, claims will be paid at the *allowed amount,* and you may be billed for any balance of costs above the *allowed amount*.

PREMIUMS

Premium Payment

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

Grace Period

When a *member* is receiving a premium subsidy:

> After the first premium is paid, a grace period of 3 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 *advance premium tax credits* are received.
>
> We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. We will notify HHS of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the second and third month of the grace period. We will continue to collect *advance premium tax credits* on behalf of the *member* from the Department of the Treasury and will return the *advance premium tax credits* on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above. A *member* is not eligible to re-enroll once terminated, unless a *member* has a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

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

> Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 60-day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *policy* will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. We will notify 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. We will mail you a notice of non-payment 15 calendar days prior to the end of your grace period.

Third Party Payment of Premiums or Cost Sharing

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

1. Ryan White HIV/AIDS program under Title XXVI of the Public Health Service Act;

2. Indian tribes, tribal organizations, or urban Indian organizations;
3. State and Federal government programs;
4. The American Kidney Fund;
5. Family members; or
6. An employer for an employee under an Individual Coverage Health Reimbursement Arrangement (ICHRA) or Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) plan.

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

Misstatement of Age

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

Change or Misstatement of Residence

If you change your *residence*, you must notify the Health Insurance Marketplace 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 and Limited Enrollment 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 *policy,* we have the right to rerate the *policy* back to the original *effective date*.

PRIOR AUTHORIZATION

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

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.

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.

Prior Authorization Required

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

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

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

Pursuant to the federal No Surprises Act, emergency services received from a non-network provider are covered services without prior authorization.

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

1. At least 5 calendar days prior to an elective admission as an *inpatient* in a *hospital*, *extended care* or *rehabilitation facility*, or *hospice* 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 24 hours of an admission for *inpatient mental health disorder* or *substance use disorder* treatment.
5. At least 5 calendar days prior to the start of *home health care*.

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

1. For expedited reviews, 2 calendar days from the receipt of the request.
2. For prior authorization review for diagnoses related to cancer, as soon as possible but no later than 48 hours.
3. For urgent concurrent reviews 1 calendar day hours of receipt of the request.
4. For urgent *pre-service* reviews, within 3 calendar days from date of receipt of request.
5. For non-urgent *pre-service* reviews within 5 calendar days of receipt of the request.
6. For post-service or retrospective reviews, within 30 calendar days of receipt of the request.

How to Obtain Prior Authorization

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

Failure to Obtain Prior Authorization

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

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

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

Prior Authorization Does Not Guarantee Benefits

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

Denial of Prior Authorization

Refer to the Appeal, Grievance and External Review Procedures section of this *policy* for information on your right to *appeal* a denied *authorization*.

Requests for Predeterminations

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

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

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

Services from Non-Network Providers

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

COST SHARING FEATURES

Cost Sharing Features

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

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

Copayments

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

Coinsurance Percentage

A *coinsurance amount* is your share of the cost of a service. *Members* may be required to pay a *coinsurance* in addition to any applicable *deductible amount*(s) 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* has been met, additional *covered services* will be provided at 100 percent.

Deductible

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

Maximum Out-of-Pocket

You must pay any required *copayments* or *coinsurance amounts* required until you reach the *maximum out-of-pocket amount* shown in your *Schedule of Benefits*. After the *maximum out-of-pocket amount* is met for an individual, we will pay 100 percent of the cost for *covered services*. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket amount*. For the family *maximum out-of-pocket amount*, once a *member* has met the

individual *maximum out-of-pocket amount*, the remainder of the family *maximum out-of-pocket amount* can be met with the combination of any one or more *member*'s *eligible expenses*.

The amount provided or payable will be subject to:

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

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

Non-Network Liability and Balance Billing

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

ACCESS TO CARE

Primary Care Physician (PCP)

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

- Family practitioners
- General practitioners
- Internal medicine
- Nurse practitioners*
- Physician assistants
- Obstetricians/gynecologists
- Pediatricians (for children)

*If you choose a nurse practitioner as your *PCP*, your benefit coverage and *copayment amounts* are the same as they would be for services from other *network providers*. See your *Schedule of Benefits* for more information.

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

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 specialist physicians*
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.

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

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

Contacting Your Primary Care Physician (PCP)

To make an appointment with your *PCP*, call his/her office during business hours and set up a date and time. If you need help, call Member Services and we will help you make the appointment.

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

Should you need care outside of your *PCP's* office hours, you should call your *PCP's* office for information on receiving after hours care in your area. If you have an urgent medical problem or question or cannot reach your *PCP* during normal office hours, call our 24/7 nurse advice line at 1-833-635-0450 (TTY 711). A licensed nurse is always available and ready to answer your health questions. In an emergency, call 911 or head straight to the nearest emergency room.

Changing Your Primary Care Physician (PCP)

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

Referral Required for Maximum Benefits

You do not need a referral from your *network PCP* for obstetrical or gynecological treatment from a *network* obstetrician or gynecologist. For all other *network specialist physicians,* you may be required to obtain a referral from your *network PCP* for benefits to be payable under your *policy* or benefits payable under this *policy* may be reduced. Please refer to your *Schedule of Benefits*.

Network Availability

Your *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 *policy* and enroll in a different health plan with a *network* in that area. **Note:** *Covered services* received from *non-network providers* are generally not *covered services* under this *policy,* 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 *policy* for *non-network providers*.

Coverage Under Other Policy Provisions

Charges for services and supplies that qualify as *covered service* expenses under one benefit provision will not qualify as *covered service* expenses under any other benefit provision of this *policy.*

Non-Emergency Services

If you are traveling outside of the Louisiana *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 Louisiana 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* 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 to 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. Payments of claims for *emergency medical services* rendered by a *non-network provider* are not made directly to you.

Pre-admission Testing

Benefits will be provided for the *outpatient facility* charge and associated professional fees for diagnostic services rendered within 72 hours of a scheduled procedure performed at an *inpatient* or *outpatient facility*.

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 or *facility* is terminated, such that the provider or *facility* is no longer in *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;
2. Provide the member with an opportunity to notify the health plan 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 above notice is provided and ending on the earlier of:
   a) The 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 their provider.

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*.

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 Partnership

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

MAJOR MEDICAL EXPENSE BENEFITS

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 disorder* and *substance use disorder* services, including *behavioral health* treatment, *prescription drugs*, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. *Essential health benefits* provided within this *policy* are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime or annual dollar maximum.

Acquired Brain Injury Services

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

1. Cognitive rehabilitation therapy;
2. Neurocognitive therapy and rehabilitation;
3. Neurobehavioral, neuropsychological, neurophysiological, and psychophysiological testing and treatment;
4. Neurofeedback therapy;
5. Remediation required for and related to treatment of an acquired brain injury;
6. Post-acute transition services and community reintegration services, including outpatient day treatment services, or any other post-acute treatment services.

Treatment for an *acquired brain injury* may be provided at a *hospital*, an acute or post-acute *rehabilitation hospital*, an assisted living facility or any other facility at which appropriate services or therapies may be provided. Services means the work of testing, treatment and providing therapies to an individual with an *acquired brain injury*. Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an *acquired brain injury*.

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

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

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

Ambulance Service

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 the *member's emergency condition*.
2. To the nearest available *hospital* or 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. For the *temporarily medically disabled mother* of an ill *newly born* infant when accompanying the ill *newly born* infant to the nearest *hospital* or neonatal special care unit, upon recommendation by the mother's attending *physician* of her need for professional ambulance service.
4. Transportation between *hospitals* or between a *hospital* and a skilled nursing or *rehabilitation facility* when authorized by us.
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*.
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 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, (for example, commercial flights).

Benefits for air *ambulance services* are limited to:

1. Services requested by police or medical authorities at the site of an *emergency*.

2. Those situations in which the *member* is in a location that cannot be reached by ground ambulance.

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 services appropriate to the *member's emergency condition*.
2. To the nearest available *hospital* or 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. For the *temporarily medically disabled mother* of an ill *newly born* infant when accompanying the ill *newly born* infant to the nearest *hospital* or neonatal special care unit, upon recommendation by the mother's attending *physician* of her need for professional ambulance service.
4. Transportation between *hospitals* or between a *hospital* and a skilled nursing or *rehabilitation facility* when authorized by us.
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. You should not be *balance billed* for covered emergency services from a non-network ambulance provider, beyond your *cost share*, for ground and water ambulance services. **Note:** Non-emergency ambulance transportation requires *prior authorization*

Unless otherwise required by Federal or Louisiana law, if you receive services from non-network ambulance providers, you may be *balanced 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 (for example, transport-van, taxi, ride sharing).

Ambulatory Patient Services

Covered service and supply expenses for ambulatory patient services will include *medically necessary* services delivered in settings other than a *hospital* or *rehabilitation* or *extended care facility*, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat *illness* or *injury*. Such services include:

1. *Hospice* and *home health care*, including skilled nursing care as an alternative to hospitalization;
2. Provider office visits and treatments, and associated supplies and services, including therapeutic injections and related supplies;
3. *Urgent care center* visits, including provider services, facility costs and supplies;
4. Ambulatory surgery center (see below provision);

5. Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures;
6. Oral *surgery* related to trauma and *injury*, including services or appliances necessary for, or resulting from medical treatment if the service is either emergency in nature or requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease; and
7. *Physician* contraceptive services and supplies including, but not limited to, vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.

Ambulatory Surgical Center

Outpatient services and supplies provided at a *network* ambulatory surgery center including:

1. Anesthesiology;
2. Surgical services;
3. Laboratory services;
4. Recovery care;
5. Patient care services;
6. Surgical supplies; and
7. Facility costs (including services of staff providers billed by the *hospital*).

Attention Deficit/Hyperactivity Disorder

The diagnosis and treatment for Attention Deficit/Hyperactivity Disorder is *covered* when rendered or prescribed by a *physician*. You must pay the *copayment*, *deductible*, and *coinsurance* that apply to the type of provider rendering services for this condition.

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. *habilitation services* for individuals with a diagnosis of *autism spectrum disorder*;
5. speech therapy;
6. occupational therapy;
7. physical therapy;
8. psychiatric care such as counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor, or clinical social worker; and
9. medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

These services are subject to *prior authorization* to determine medical necessity. If multiple services are provided on the same day by different providers, a separate *copayment* and/or *coinsurance* will apply to each provider.

Chiropractic Services

We cover *medically necessary* chiropractic care provided on an outpatient basis. See the *Schedule of Benefits* for applicable *cost share* and limits.

Cleft Lip and Cleft Palate Services

The following services for treatment and correction of *cleft lip and cleft palate* are *covered*:

1. oral and facial *surgery*, surgical management, and follow-up care;
2. prosthetic treatment, such as obturators, speech appliances, and feeding appliances;
3. orthodontic treatment and management;
4. preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy;
5. speech/language evaluation and therapy;
6. audiological assessments and amplification devices;
7. otolaryngology treatment and management;
8. psychological assessment and counseling; and
9. genetic assessment and counseling for patient and parents.

Coverage is also provided for secondary conditions and treatment attributable to the primary medical condition.

Clinical Trial Coverage

Clinical Trial Coverage includes routine patient care costs incurred as the result of an approved phase I, II, III, or phase IV clinical trial and the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition.

Coverage will include routine patient care costs incurred for:

1. Drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition,
2. Reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial and
3. All items and services that are otherwise generally available to a *qualified individual* that are provided in the clinical trial except:
   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 insured's who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

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

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 *policy*.

COVID-19 Services

Approved diagnostic tests, antibody tests, and antiviral drugs that are ordered by your *physician* for the purpose of making clinical decisions or treating you if you are suspected of having COVID-19 are covered under this *policy*.

The approved diagnostic tests and antibody tests do not include a test used for employment-related or public health surveillance testing and, regardless of medical necessity, any COVID-19 diagnostic tests or antibody tests for those purposes are excluded from coverage.

Diabetic Care

Benefits are available for *medically necessary* services items and of diabetic supplies used in the treatment of persons with gestational, type I or type II diabetes when they are prescribed by a *provider.*

Covered services include, but are not limited to:

1. Examinations (including podiatric examinations);
2. Laboratory and radiological diagnostic testing;
3. Self-management equipment;
4. Supplies such as urine or ketone strips;
2. Blood glucose monitors (including non-invasive monitors and monitors for the blind);

3. Supplies (glucose strips) for the device;
4. Syringes or needles;
5. Orthotics and diabetic shoes;
6. Urinary protein/microalbumin and lipid profiles;
7. Educational health and nutritional counseling for self-management;
8. Eye examinations;
9. Prescription medications; and
10. One retinopathy examination screening per year.

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

Diabetes self-management training and education will be provided on an outpatient basis when done by a registered or licensed health care professional that is certified in diabetes.

Dialysis Services

Medically necessary acute and chronic dialysis services are *covered services* unless other coverage is primary, such as Medicare for dialysis. There are two types of treatment provided you meet all the criteria for treatment. You may receive hemodialysis or peritoneal dialysis in your home when you qualify for home dialysis.

Covered services include:

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

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

Dietician Visits

Benefits are available for outpatient visits to registered dieticians. One (1) dietician visit is covered at no cost to *members* when performed by a *network provider*. All other subsequent dietician visits are covered according to the *cost share* as outlined in your *Schedule of Benefits*. Diabetics that need the services of a dietician should receive those services as part of their benefits for diabetic care.

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 amount* for a standard item that is a *covered service*, serves the same purpose, and is *medically necessary*. Any expense that exceeds the *maximum 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.

Disposable Medical Supplies

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

Durable Medical Equipment

The rental (or, at our option, the purchase) of *durable medical equipment* prescribed by a *physician* or other provider. *Durable medical equipment* is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of *illness*

or *injury*; and is appropriate for use in a patient's home. Examples include, but are not limited to, wheelchairs, crutches, *hospital* beds, and oxygen equipment. Rental cost must not be more than the purchase price. We will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are *covered services*. Payment for related supplies is a *covered service* only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the *member*; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered services and supplies may include, but are not limited to:

1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for 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.

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

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. Trans lift chairs.
6. Treadmill exerciser.
7. Tub chair used in shower.

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

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

Covered services and supplies may include, but are not limited to:

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

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

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

Orthotic Devices

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

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

1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.
10. *Medically necessary* corrective footwear, *prior authorization* may be required.
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 an orthotic device is damaged and cannot be repaired.

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

1. Foot support devices, such as arch supports, unless they are an integral part of a leg brace.
2. 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 if:

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

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

Covered services and supplies may include, but are not limited to:

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

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. Penile prosthesis in adults suffering impotency resulting from disease or *injury*.

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 the 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 appropriate).
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. 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.

Fertility Preservation

Medically necessary fertility preservation services for *enrollees* when a medical treatment will directly or indirectly result in "iatrogenic infertility," which is an impairment of fertility by *surgery*, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes. *Cost-sharing* such as *deductibles, copayments*, and *coinsurance* may be imposed on fertility preservation services if the *cost-sharing* is consistent with other benefits in the *contract* and place of service. Services include the collecting, freezing, preserving of ova or sperm, and other standard services that are not *experimental or investigational*. Coverage includes up to three (3) years of storage costs associated with oocytes and sperm during the enrollee's membership.

Coverage may be limited to *in-network providers* for fertility preservation services unless the issuer does not have an *in-network provider* with the appropriate training and expertise to meet the needs of the *enrollee*.

Habilitation Expense Benefits

Inpatient and outpatient *habilitation services* are a *covered service*. *Covered services* include: physical, occupational and speech therapies, developmental services, *durable medical equipment* for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder.

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

Hearing Benefits

Benefits are available for hearing aids when *medically necessary* and obtained from a *network provider*. This benefit is limited to one hearing aid for each ear with hearing loss every 36 months. The hearing aid must be fitted and dispensed by a licensed audiologist, licensed hearing aid specialist or a hearing aid dealer after the medical clearance of a *physician* and an audiological evaluation. **Note:** You may choose a hearing aid that is priced higher than the benefit payable (based on the *network provider's* contracted amount) and pay the difference between the price of the hearing aid and the benefit payable, without financial or contractual penalty to the provider of the hearing aid.

Implantable bone conduction hearing aids, cochlear implants, and bone-anchored hearing aids (BAHA) are covered for all *members*, regardless of age, the same as any other service or supply, subject to *medical necessity* and payment of applicable *deductible amounts*, *copayment amounts* and *coinsurance amounts*.

Home Health Care Service Expense Benefits

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

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

Intravenous (I.V.) medication and pain medication are *covered services* to the extent they would have been *covered service*s during an *inpatient hospital* stay. At our option, we may *authorize* the purchase of the equipment from a *network provider* in lieu of its rental if the rental

price is projected to exceed the equipment purchase price, but only from a provider we *authorize* before the purchase.

Limitations:
Home health care services and benefits are subject to *prior authorization* requirements as outlined in this *policy*. See your *Schedule of Benefits* for benefit levels or additional limits for expenses related to *home health aide services*.

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

Hospital Benefits

Covered services are limited to charges made by a *hospital* for:

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

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 in your *network*. 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.*

Long Term Acute Care (LTACH)

Long-term acute care *hospitals* (LTACHs) furnish extended medical and rehabilitative care to individuals with clinically complex problems, such as multiple acute or chronic conditions, that need hospital-level care for relatively extended periods when *medically necessary* and approved by us. LTACH benefits are subject to *prior authorization requirements* as outlined in this *policy*.

Common conditions/services that may be considered *medically necessary* for LTACH level of care includes, 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, 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 six hours or more per day
    c. Ventilator management required at least every four 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 disorders.

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

Hospice Care Service Expense Benefits

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

The list of *covered services* include:

1. Room and board in a *hospice* while the *member* is an *inpatient.*
2. Occupational therapy.
3. Speech-language therapy.

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

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

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

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

Infertility

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

1. Endometriosis;
2. Collapsed/clogged fallopian tubes; or
3. Testicular failure.

This benefit is subject to *deductible amounts*, *copayment amounts* and *coinsurance amounts*.

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

Interpreter Expenses for the Deaf or Hard of Hearing

Services performed by a qualified interpreter or transliterator are covered when you need such services in connection with medical treatment or diagnostic consultations performed by a provider if the services are required because of hearing loss or your failure to understand or otherwise communicate in spoken language. Services rendered by a family member are not covered.

Lymphedema Benefit

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

Mammography

We include benefits payable for minimum mammography examination, including but not limited to digital breast tomosynthesis (DBT). Minimum mammography examination means mammography examinations performed no less frequently than the following schedule provides:

1. One baseline mammogram for any woman who is 35 through 39 years of age.
2. Annual mammogram (DBT preferred modality) for any woman who is 40 or older.
3. Consideration is given to women with a hereditary susceptibility from pathogenic mutation carrier status or prior chest wall radiation, an annual Magnetic Resonance Imaging (MRI) starting at age 25 and annual mammography (DBT preferred modality) starting at age 30.

Such examinations shall be in accordance with recommendations by National Comprehensive Cancer Network guidelines or the American Society of Breast Surgeons Position Statement on Screening Mammography no later than the following policy or plan year following changes in the recommendations. Annual mammography (DBT preferred modality) and access to supplemental imaging (MRI preferred modality) starting at age thirty-five upon recommendation by her *physician* if the woman has a predicted lifetime risk greater than twenty percent by any validated model published in peer reviewed medical literature.

Maternity Care

Coverage for outpatient and *inpatient* pre- and post-partum care including examinations, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and *hospital* stays for delivery or other *medically necessary* reasons (less any applicable *deductible amounts*, *copayment amounts* or *coinsurance amounts*). An *inpatient* stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a cesarean delivery. We do not require that a *physician* or other health care provider obtain *prior authorization* for deliveries. An *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require notification to us. Other maternity benefits include *complications of pregnancy,* maternity support services provided by doulas, parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests. Coverage will only be provided for maternity services or care of the newborn child when such services have been *authorized* by your *network* health care *provider*.

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, we may provide benefits for *covered service* expenses incurred for a shorter stay if the attending provider (e.g., your *physician*, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

The level of benefits and out-of-pocket costs for any later part of the 48-hour (or 96-hour) stay will not be less favorable to the mother or newborn than any earlier part of the stay. We do not

require that a *physician* or other health care provider obtain *authorization* for prescribing a length of stay of up to 48 hours (or 96 hours).

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

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

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

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 Ambetter from Louisiana Healthcare Connections, Member Services, P.O. Box 84180, Baton Rouge, LA 70884. In the event that a *member* fails to comply with this provision, we reserve our right to enforce this *policy* on the bases of fraud, misrepresentation, or false information, up to and including recoupment of all benefits that we paid on behalf of the *surrogate* during the time that the *surrogate* was insured under our *policy*, plus interest, attorneys' fees, costs, and all other remedies available to us.

Genetic Testing for Critically Ill Infants
When ordered by your *physician*, benefits will be provided for *medically necessary* diagnostic testing using advanced molecular techniques including but not limited to:

- traditional whole genome sequencing;
- rapid whole genome sequencing; and
- other genetic and genomic screening that includes:
    - individual sequencing;
    - trio sequencing for a parent or parents of the infant; and
    - ultra-rapid sequencing for an infant who is one year of age or younger and is receiving *inpatient hospital* services in an *intensive care unit* or in a pediatric care unit and has a complex *illness* of unknown etiology.

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

Newborns' and Mothers' Health Protection Act Statement of Rights

If services provided or expenses incurred for *hospital* confinement in connection with childbirth are otherwise included as *covered service* expenses, we will not limit the number of days for these expenses to less than that stated in this provision.

Medical and Surgical Expense Benefits

Covered services provided under this provision are subject to all other terms and conditions of the *policy* including *deductible amount* and *cost sharing* provisions. *Covered services* may also be subject to *prior authorizations* and *cost sharing* requirements and include but are not limited to, the following services:

1. For *surgery* in a *physician's* office, an *inpatient* facility, an outpatient facility, or a *surgical facility,* including services and supplies.
2. For a qualified individual's pre-surgical and post-surgical procedures and testing, including but not limited to, diagnostic services using radiologic, ultrasonographic or laboratory services (psychometric, behavioral, and educational testing are not included):
    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.
3. For medical services in an office or facility that is provided by a licensed *medical practitioner* or *specialist physician*, including consultations and *surgery* related services.
4. For chemotherapy (including oral chemotherapy), inhalation therapy, infusion therapy, and radiation therapy or treatment in a *hospital* or office setting.
5. For biomarker testing for the purpose of diagnosis, treatment, appropriate management or ongoing monitoring of a *member's* cancer disease or condition when the test is supported by medical and scientific evidence, including but not limited to:
    a. Labeled indications for an FDA-approved or FDA-cleared test;
    b. Indicated tests for an FDA-approved drug;
    c. Warnings and precautions on FDA-approved drug labels;
    d. Centers for Medicare and Medicaid Services national coverage determinations;
    e. Nationally recognized clinical practice guidelines
6. For *durable medical equipment*, *prosthetic devices*, *orthotic devices,* or other necessary medical supplies following a medical or surgical procedure such as crutches, orthopedic splints, braces, or casts. Please see the **Durable Medical Equipment** provision of this *policy*.

7. For hemodialysis and the charges by a *hospital* or facility for the 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.
8. For the cost and administration of anesthesia, oxygen, drugs, medications, and biologicals.
9. 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.
10. 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.
11. For infertility counseling and planning services when provided by a *network* provider and testing to diagnose infertility.
12. 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 bone marrow transplants or stem cell transplants.
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 *policy* See the **Clinical Trial Coverage** provision of this *policy*.
14. For the following types of *medically necessary* implants and tissue grafts:

a. Corneal transplants
b. Artery or vein grafts
c. Heart valve grafts
d. Prosthetic tissue replacement, including joint replacements
e. Implantable prosthetic lenses, in connection with cataracts
f. Skin grafts

15. 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 *policy*.
16. For *medically necessary telehealth services. Telehealth services* not provided by *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.
17. For *surgery* or services related to cochlear implants and bone-anchored hearing aids.
18. For *medically necessary* services for complications arising from medical and surgical conditions.
19. For respiratory, pulmonary, cardiac, physical, occupational and speech therapy services. Please see **Rehabilitation and Extended Care Facility Expense Benefits and Habilitation Expense Benefits** provisions of this *policy*.
20. For maternity care services including but not limited to prenatal, postnatal, diagnostic testing, laboratory services and *hospital* services.
21. 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.
22. For *medically necessary* footcare treatment that may require *surgery*; *prior authorization* may be required.
23. 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.
24. For *medically necessary* biofeedback services.
25. For therapeutic abortion performed to save the life or health of the *member*.
26. 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.
27. For *medically necessary chiropractic care* or manipulative therapy treatment on an outpatient basis only. See your *Schedule of Benefits* for benefit levels or additional limits. *Covered services* are subject to all other terms and conditions of the *policy*, including the *deductible amount* and *cost sharing* provisions.
28. For *medically necessary* nutritional counseling, *prior authorization* may be required.
29. 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.
30. For *medically necessary* allergy testing and treatment including allergy injections and serum.
31. For second surgical opinions subject to any *copayments amounts, deductible amounts,* and *coinsurance amounts*, but are not mandatory to receive benefits.

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 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* setting and for associated *hospital* charges when the *member's* mental or physical condition requires dental treatment to be rendered in a *hospital* setting.

Coverage is also provided for:

1. *Medically necessary* oral *surgery*, including the following:
    a. Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
    b. Orthognathic *surgery* for a physical abnormality that prevents normal function of the upper and/or lower 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 (TMJ) disorder, including removable appliances for TMJ repositioning and related *surgery*, medical care, and diagnostic services.
    e. Treatment of non-dental lesions, such as removal of tumors and biopsies.
    f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
    g. *Surgical procedures* that are *medically necessary* to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.
    h. *Reconstructive surgery* to correct significant deformities caused by congenital or developmental abnormalities, *illness*, *injury,* or an earlier treatment in order to create a more normal appearance.
2. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* or office charges for dental care, rendered by a dentist, regardless of whether the services are provided in a *network hospital*, surgical center, or office, provided to the following *members*:
    a. A *member* under the age of five;
    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.

d. *Dental service* expenses when a *member* suffers an *injury*, that results in damage to his or her natural teeth. *Injury* to the natural teeth will not include any *injury* as a result of chewing.

3. *Surgery*, excluding tooth extraction, to treat craniomandibular disorders or malocclusions.

Medical Foods

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

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.

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

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

Medical Vision Services

Covered services include:

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

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

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

Mental Health and Substance Use Disorder Benefits

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

Covered services will be provided on an *inpatient* and outpatient basis and include mental health and substance use disorder diagnoses. If you need *mental health disorder* or *substance use disorder* treatment, you may choose any provider participating in our *mental health* provider *network* and do not need a referral from your *PCP* in order to initiate treatment. You can search for *network behavioral health* providers by using our “Find a Doctor” tool at Ambetter.LouisianaHealthConnect.com or by calling Member Services. *Deductible amounts, copayment*, or *coinsurance amounts* and treatment limits for covered *mental health disorder* and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

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

When making coverage determinations, our *mental 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 *mental health* Utilization Management staff utilizes Change Healthcare's InterQual criteria for mental health determinations and American Society of Addiction Medicine (ASAM) criteria for *substance use disorder* determinations.

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

Inpatient

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

Outpatient

1. Individual and group therapy for *mental health disorders* and *substance use disorders*;
2. Care for *behavioral health* that is delivered through evidence-based, integrated behavioral healthcare models, such as the psychiatric collaborative care model;
3. Medication Assisted Treatment – combines behavior therapy and medications to treat *substance use disorders*;
4. Medication management services;
5. Outpatient detoxification programs;
6. Psychological and Neuropsychological testing and assessment;
7. Evaluation and assessment for mental health and *substance use disorders*;
8. *Applied behavior analysis*;
9. Telehealth for (individual/family therapy; medication monitoring; assessment and evaluation);
10. Partial Hospitalization Program (PHP);
11. Intensive Outpatient Program (IOP);
12. Mental health day treatment;
13. Electroconvulsive Therapy (ECT);
14. *Transcranial magnetic stimulation (TMS)*;

The diagnosis and treatment for attention deficit/hyperactivity disorder when rendered or prescribed by a licensed *physician* or other *health care* provider licensed in this state and received in an appropriate setting.

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

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

Metastatic or Unresectable Tumors

We cover metastatic or unresectable tumors and other advanced cancers with a *medically necessary* drug prescribed by a *physician* on the basis that the drug is not indicated for specific tumor type or the location in the body in a different type of cancer if the drug is approved by the United States Food and Drug Administration for the treatment of the specific mutation of the patient's cancer. *Coverage* is included for an initial treatment period of three (3) months. *Coverage* shall continue after the initial treatment period, if the treating *physician* certifies that the drug is *medically necessary* based on documented improvement of the patient.

Outpatient Medical Supplies Expense Benefits

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

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including *medically necessary* repairs or replacement to restore or maintain a ***member's*** ability to perform activities of daily living or essential job-related activities.
2. For one pair of foot orthotics per year per *member*.
3. For mastectomy bras if the *member* has undergone a covered mastectomy.

4. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
5. For the rental of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint *surgery*.
6. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns.
7. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract *surgery*.

Pediatric Routine Vision Expense 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. This plan is compliant with the FEDVIP 2014 Vision Benefit Plan.

1. Routine ophthalmological examination
    a. Refraction;
    b. Dilation.
2. Standard frames
3. Prescription lenses
    a. Single;
    b. Bifocal;
    c. Trifocal;
    d. Lenticular
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. Subject to *prior authorization*, *members* with low vision will receive the following:
    a. One comprehensive evaluation every 5 years. This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast and lighting requirements for optimum vision.
    b. One device per year such as high-power spectacles, magnifiers, and telescopes. These devices maximum use of available vision, reduce problems of glare or

increase contrast perception, based on the person's visual goals and lifestyle needs.

c. Four follow-up visits in any five-year period.

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

Covered services do not include:

1. Deluxe frame/frame upgrade;
2. Visual therapy (see medical coverage);
3. Two pair of glasses as a substitute for bifocals;
4. LASIK surgery; and
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. Coverage for drugs include all benefits associated with the cost of the drug including taxes and fees as applicable minus member standard *cost share* and accumulators. *Covered services* in this benefit provision are limited to charges from a licensed *pharmacy* for:

1. A *prescription drug.*
2. Prescribed, self-administered anti-cancer medication.
3. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician.*
4. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one (1) *standard reference compendium*; or
    b. The drug is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
5. Off-label drugs for a *member* under the age of 18 provided that:
    a. The drug has been approved by the United States Food and Drug Administration.
    b. The drug has been prescribed by a licensed *provider* for the treatment of a life threatening, chronic, or seriously debilitating disease or condition in the minor and the drug has been approved by the United States Food and Drug Administration for the same condition or disease in an adult and the drug is medically necessary to treat the disease or condition.
    c. The drug has been recognized for the treatment of the disease or condition in pediatric application by one of the following:
        i. The American Medical Association Drug Evaluations
        ii. The American Hospital Formulary Service Drug Information
        iii. The United States Pharmacopeia Dispensing Information, Volume 1, "Drug Information for the Healthcare Professional"
        iv. Recognized in two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally

safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed journal.

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

Formulary or Prescription Drug List
This plan uses one *formulary* for all products covered under this *policy*. No product offered under this *policy* is issued without a *formulary*.

The formulary or *prescription drug* list is a guide to available generic, brand name drugs and some over-the-counter medications when ordered by a *physician* that are approved by the Food and Drug Administration (FDA) and covered through your *prescription drug* benefit. The *formulary* lists drugs on different tiers which represent varying *cost share* amounts. In general, drugs listed on lower *formulary* tier will be associated with lower *member cost share* amount. Most generic medications are listed on the lowest formulary *cost share* tier. 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 higher on the Drug List tier than generic drugs to help identify brand name drugs that are clinically appropriate, safe, and cost-effective treatment options, if a generic medication on the formulary is not suitable for your condition. **Note:** Not all dosage forms or strengths of a drug may be covered. If a drug is not listed on the formulary, it means that the drug is not covered, and it is considered non-formulary. You have the right to request a non-formulary exception request review from us. Please review the Prescription Drug Exception Process provision below for additional information.

This list is reviewed and updated at least quarterly. Positive changes, such as removal of utilization management restrictions and addition of drugs to the formulary can take place monthly. Negative changes, such as addition of *prior authorization* requirement will take place only at the beginning of each new benefit year. The formulary is reviewed by our Pharmacy and Therapeutics Committee (P&T). The P&T, consisting of practicing *physicians*, pharmacists, and dentist, evaluates clinical aspects of each drug. Strategy Development Committee, a subcommittee of the P&T consisting of data analysts and pharmacists, determines the financial aspects of each drug. Together those two committees determine drug placement and any utilization management restrictions. If two drugs are clinically expected to produce same outcomes, then the placement of the drug is based on financial aspects.

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.LouisianaHealthConnect.com (under “For Member,” “Drug Coverage”) or call Member Services.

Step Therapy

Step therapy means a utilization management policy for coverage of drugs that begins medication for a medical condition with the most preferred or cost-effective drug therapy and progresses to other drug therapies if *medically necessary*. Step therapy is part of our formulary design and design of this plan.

Notice of Disclosure of Prescription Drug Formulary
We offer several convenient ways to obtain and review current formulary and inquire if a drug is covered on the *formulary*. For the most current Ambetter Formulary or Prescription Drug List or for more information about our pharmacy program, visit Ambetter.LouisianaHealthConnect.com (under "For Member," "Drug Coverage") or call Member Services. If a *prescription drug* is on your Prescription Drug Formulary, this does not guarantee that your prescribing health care provider will prescribe it for a particular medical condition or mental *illness*. We will disclose to you upon request, not later than the third business day after the date of the request, whether a specific drug is included in our drug formulary.

Notice on Excess Cost
We use any savings or rebates to stabilize rates. Any savings or rebates we receive on the cost of drugs purchased under this *policy* from drug manufacturers are used to stabilize rates. You may be subject to an excess consumer cost burden when *covered prescription drugs* are purchased under this *policy*.

Notification to Providers
If a prescribed drug is denied based upon the drug's nonformulary status, we will provide the prescriber with a list of alternative comparable formulary medications in writing and attached to the letter of denial or electronically for requests made by providers utilizing electronic health records with capabilities. If a prescribed drug is excluded from coverage under the health benefit plan and other drugs in the same class and used for the same treatment as the excluded drug are covered under the plan, we will notify the prescriber of the covered drug in writing and attached to the letter of denial or electronically for requests made by providers utilizing electronic health records with capabilities.

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

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

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

We also offer a three-month (90-day) supply of maintenance medications by mail or from *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.LouisianaHealthConnect.com. You can also request to have a copy mailed directly to you.

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

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

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.

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

Medication Balance-On-Hand
Medication refills are prohibited until your cumulative balance-on-hand is equal to or fewer than 15 calendar days’ supply of medication. This program operates in addition to any applicable medication quantity limit or refill guidelines.

Split-Fill Dispensing Program
You are limited to 15-day supplies for the first 90 calendar days when starting new therapy using certain medications (like oral oncology). You 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 calendar days, you will fill your medications for 30-day supplies.

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

Exception to Step Therapy or Fail First Protocol
We will grant exception to step therapy or fail first protocol when:

1. The prescribing *physician* can demonstrate to the health coverage plan, based on sound clinical evidence, that the preferred treatment required under step therapy or fail first protocol has been ineffective in the treatment of the insured's disease or medical condition.
2. The prescribing *physician* can demonstrate to the health coverage plan, based on sound clinical evidence, that the preferred treatment required under the step therapy or fail first protocol is reasonably expected to be ineffective based on the known relevant physical or mental characteristics and medical history of the insured and known characteristics of the drug regimen.
3. The prescribing *physician* can demonstrate to the health coverage plan, based on sound clinical evidence, that the preferred treatment required under the step therapy or fail first protocol will cause or will likely cause an adverse reaction or other physical harm to the insured.

For product approved under this section we will issue an *approval* letter outlining coverage under this *policy*. For any product denied under this section you have the right to *appeal* our decision. Any product requested under this section will be reviewed within 72 hours of receipt of the request for standard requests and within 24 hours of receipt of urgent or exigent request.

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

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

exception request be granted, we will provide coverage of the non-formulary drug or the drug that is the subject of the protocol exception for the duration of the exigency.

If we do not respond to exception requests as outlined above, such exception should be deemed approved.

External exception request review
If we deny a request for a standard exception or for an expedited exception, the *member*, the *member's* designee, 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. The independent review organization will make a determination on the external exception request and notify the *member*, the *member's* designee, or the *member's* prescribing *physician* of the coverage determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request if the original request was an expedited exception.

We will cover any medication approved under the exception requests described above for the duration stated on the original request or 12 months, whichever is shorter. Subsequent coverage may necessitate further reviews.

We do not apply fail first or step therapy protocols for drugs used in treatment of stage-four advanced metastatic cancer or associated conditions. This is reflected in our *prior authorization* criteria.

Notification of change in prescription drug or intravenous infusion coverage
If we change our coverage of a particular *prescription drug* or intravenous infusion based on medical necessity and you were utilizing this product in the past for at least 60 calendar days, we will provide you with at least 60 calendar days advanced notice of proposed change. You have the right to *appeal* this proposed change. To start the *appeal* process please reach out to your provider. Your provider can utilize regular *appeals* process for purposes of this section.

Change in formulary coverage
We will remove drugs from the formulary or otherwise restrict drugs with utilization management techniques only once a year at the time of the renewal.

Oral cancer drugs
We will provide oral cancer drugs at no less favorable terms than intravenously administer or injected cancer medications. This provision does not apply if you are on a High Deductible Health Plan or policies used together with a health savings account, medical savings account, or similar program.

Cost share contribution
Any *copay* or *cost share* amount paid by you or on your behalf by a *third party* will be counted in your annual accumulators.

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

21. For any drug related to *surrogate pregnancy*.
22. For any injectable medication or biological product that is not expected to be self-administered by the *member* at *member's* place of *residence* unless listed on the formulary.
23. Medication refills where a *member* has more than 15 calendar days' supply of medication on hand.
24. Compound drugs unless there is at least one ingredient that is an FDA approved drug.
25. For any prescription or over-the-counter version of vitamin(s) unless otherwise included on the formulary.

Preventive Care Expense Benefits

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

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
4. With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA 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 amount*, *copayment amount* or *coinsurance amount*). For current information regarding available preventive care benefits, please access the Federal Government's website at: http://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.

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 Ambetter.LouisianaHealthConnect.com. Either go to our website directly or if you need to request a paper copy, please contact Member Services for assistance.

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

Covered preventive services include, but are not limited to:

a. Routine wellness physical examination – certain routine wellness diagnostic tests ordered by your *physician* are covered. Examples of routine wellness diagnostic tests include tests such as a urinalysis, complete blood count (CBC), serum chemistries, calcium, potassium, cholesterol, and blood sugar levels.
b. Well baby care – routine examinations will be covered for infants younger than 24 months old for whom no diagnosis is made.
c. Routine annual visits to an obstetrician or gynecologist. Additional visits that your obstetrician or gynecologist recommends may be subject to a *deductible amount*, *copayment amount* or *coinsurance amount* shown on your *Schedule of Benefits*, unless they are preventive services.
d. One routine pap smear per *calendar year*.
e. All preventive film mammograms, 3-D mammograms (digital breast tomosynthesis), and breast ultrasounds are covered at no cost to you when obtained from a *network provider*.
f. Bone Mass Measurement for a qualified individual or for postmenopausal women at increased risk of osteoporosis – scientifically proven tests for diagnosing and treating osteoporosis if a *member* is:
    i. An estrogen deficient woman at clinical risk of osteoporosis who is considering treatment;
    ii. An individual receiving long-term steroid therapy; or
    iii. An individual being monitored to assess the response to or efficiency of approved osteoporosis drug therapies.
g. BRCA1 & BRCA2 Genetic Testing – genetic testing of BRCA1 and BRCA2 genes to detect an increased risk of breast and ovarian cancer when recommended by a health care provider in accordance with the United States Preventive Services Task Force.
h. Screening for nicotine or tobacco use; and
i. For those who use nicotine or tobacco products, at least two cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
    i. Four nicotine or tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling, and individual counseling) without *prior authorization*; and
    ii. All Food and Drug Administration (FDA) approved nicotine or tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without *prior authorization*.

Prostate Specific Antigen Testing

Covered services include an annual digital rectal examination and prostate-specific antigen tests performed to determine the level of prostate specific antigen in the blood at least annually, with a second visit permitted based upon medical need, and follow up treatment within 60 calendar days after either visit if related to a condition diagnosed or treated during the visit for a *member* who is at least 50 years of age; *Covered services* will also be available for a *member* who is less than 50 years of age when *medically necessary* and appropriate.

Radiology, Imaging and Other Diagnostic Testing

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

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.

Rehabilitation and Extended Care Facility Expense Benefits

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

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

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

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

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

Second Medical Opinion

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

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

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

Sleep Studies

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

Social Determinants of Health Supplemental Benefits

Social determinants of health supplemental benefits and services may be offered to *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 *policy*. The benefits and services provided may include transportation to health services, assistance with childcare, access to healthy meals, and other relevant services based on need. The benefits are available as long as coverage remains active, unless changed by us. Upon termination of coverage, the benefits are no longer available. All *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 *policy* by this reference and are subject to change by us through an update to information available on our website or by contacting us.

Social determinants of health benefits and services may be offered to *enrollees* through the "My Health Pays" wellness program and through our websites. *Enrollees* may receive notifications about available benefits and services through emails and/or through the "My Health Pays" notification system. To inquire about these benefits and services or other benefits available, you may visit our website at Ambetter.LouisianaHealthConnect.com or by contacting Member Services.

Transplant Expense Benefits

Covered services for transplant service expenses:

Transplants are a *covered service* when a *member* is accepted as a transplant candidate and pre-authorized in accordance with this *policy*. *Prior authorization* must be obtained through the *"Center of Excellence" before* an evaluation for a transplant. We may require additional information such as testing and/or treatment before determining medical necessity for the

transplant benefit. *Authorization* must be obtained prior to performing any related services to the transplant *surgery*. Transplant services must meet medical criteria as set by Medical Management Policy.

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

1. If both the donor and recipient have coverage provided by the same insurer each will have their benefits paid by their own coverage program.
2. If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this *policy* will be provided for both you and the donor. In this case, payments made for the donor will be charged against *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 *policy* will be provided for you. However, no benefits will be provided for the recipient.
4. If lapse in coverage due to non-payment of premium, no services related to transplants will be paid as a *covered service*.

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

1. Pre-transplant evaluation.
2. Pre-transplant harvesting of the organ from the donor.
3. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
4. Including outpatient *covered services* related to the transplant *surgery*, pre- transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection, and other immunosuppressive drug therapy, etc.
5. Pre-transplant stabilization, meaning an *inpatient* stay to *medically stabilization* to prepare for a later transplant, whether or not the transplant occurs.
6. The transplant itself, including the acquisition cost for the organ or bone marrow when authorized through the *Center of Excellence* and services are performed at a *network facility*.
7. Post-transplant follow-up visits and treatments.
8. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.
9. All costs incurred and medical expenses by the donor; shall be paid under the transplant recipient policy. This excludes travel, lodging, food, and mileage. Please refer to the Member Transplant Travel Reimbursement Policy for outlined details on reimbursement limitations. (ambetter.louisianahealthconnect.com/resources/handbooks-forms.html).

These medical expenses are covered to the extent that the benefits remain and are available under the *enrollee's policy*, after benefits for the *enrollee'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 *enrollee's policy*.

Ancillary "*Center of Excellence*" Service Benefits:

An *enrollee* may obtain services in connection with a transplant from any *physician*. However, if a transplant is performed in a *Center of Excellence*:

1. We will pay for the following services when the *enrollee* is required to travel more than 60 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 *enrollee*, any live donor, and the *immediate family* to accompany to and from the *Center of Excellence*, in the United States.
    b. When *enrollee* 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 *enrollee* while the *enrollee* is confined in the *Center of Excellence* in the United States. We will reimburse *members* for the proof of costs directly related for transportation, lodging and any of the following approved items listed in the *member* transplant reimbursement guidelines. However, you must make the arrangements and provide the necessary paid receipts for reimbursement within 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.louisianahealthconnect.com/resources/handbooks-forms.html.

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

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

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

Organ Transplant Medication Notification

Members will not be subject to any formulary change that alters the terms of coverage for a patient receiving *immunosuppressant drugs* or discontinues coverage for a prescribed immunosuppressant drug that a patient is receiving during the enrollment year. We must, to the extent possible, notify the prescribing *physician* and the patient, or the parent or legal guardian if the *member* is a child, or the *spouse*/caretaker of a *member* who is authorized to consent to the treatment of the *member* 60 calendar days prior to renewal or enrollment. The notification will be in writing and will disclose the formulary change, indicate that the prescribing *physician* may initiate an *appeal*, and include information regarding the procedure for the prescribing *physician* to initiate the *policy's appeal* process.

As an alternative to providing written notice, we may provide the notice electronically if, and only if, the *member* affirmatively elects to receive such notice electronically. The notification shall disclose the formulary change, indicate that the prescribing *physician* may initiate an *appeal*, and include information regarding the procedure for the prescribing *physician* to initiate the *policy's appeal* process.

At the time a *member* requests a refill of the immunosuppressant drug, we may provide the

member with the written notification required above along with a 60-day supply of the immunosuppressant drug under the same terms as previously allowed.

Urgent Care

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

Members are encouraged to contact their *PCP* for an appointment before seeking care from another provider, but *network urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *PCP* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-833-635-0450 (TTY 711). The 24/7 Nurse Advice Line is available 24 hours a day, seven days a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

Wellness Program Benefits

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

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

You may obtain information regarding the particular programs available at any given time by visiting our website at Ambetter.LouisianaHealthConnect.com or by contacting Member Services by telephone. The benefits are available as long as coverage remains active, unless changed by us as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All *members* are automatically eligible for program benefits upon obtaining coverage. These programs are optional, and the benefits are made available at no additional cost to the *members*. The programs and benefits available at any given time are made part of this *policy* by this reference and are subject to change by us through updates available on our website or by contacting us.

Care Management Programs

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

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 *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.

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *member* in the absence of insurance covering the charge.
2. Expenses, fees, taxes, or surcharges imposed on the *member* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.
3. Any services performed by a *member* of the *member's immediate family.*
4. Any services not identified and included as *covered service* expenses under the *policy*. You will be fully responsible for payment for any services that are not *covered service* expenses.
5. Any services where other coverage is primary to Ambetter must be first paid by the primary payor prior to consideration for coverage under Ambetter.

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*.
2. For any portion of the charges that are in excess of the *eligible expense.*
3. For weight modification or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*, and bariatric *surgery*, except as specifically covered in the Major Medical Expense Benefits section of this *policy*.
4. For weight loss programs, gym memberships, exercise equipment or meal preparation programs.
5. For the reversal of sterilization and the reversal of vasectomies.
6. For abortion, unless required by applicable state law.
7. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service* expenses of the Major Medical Expense Benefits provision.
8. For expenses for television, telephone, or expenses for other persons.
9. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
10. For telephone consultations between *providers* or for failure to keep a scheduled appointment.
11. For stand-by availability of a *medical practitioner* when no treatment is rendered.
12. For *dental service* expenses, including braces for any medical or dental condition, *surgery,* and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits.
13. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* or is performed to correct a birth defect.
14. Mental health services are excluded for:

a. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
b. Pre-marital counseling;
c. Court ordered care or testing or required as a condition of parole or probation. Benefits will be allowed for services that are *medically necessary* and would otherwise be covered under this *policy*;
d. Testing of aptitude, ability, intelligence, or interest; and
e. Evaluation for the purpose of maintaining employment.

15. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits provision under the Major Medical Expense Benefits section.
16. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
17. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *policy)*.
18. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*.
19. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *policy*.
20. For hearing aids, except as expressly provided in this *policy*.
21. 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. Costs of *investigational treatment(s)* and costs of associated protocol-related patient care shall be covered only if the following criteria are met:
    a. The treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer.
    b. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer.
    c. The treatment is being provided in accordance with a clinical trial approved by qualifying entities.

    A health insurance issuer is not required to provide coverage for:
    a. Non-health care services.
    b. Costs for managing research data.
    c. Investigational drugs, devices, items, or services.
22. 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* workers' compensation claim, this exclusion will still apply unless that denial is *appealed* to the proper governmental agency and the denial is upheld by that agency.
23. For fetal reduction *surgery*.

24. Except as specifically identified as a *covered service* under the *policy*, 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.
25. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or Semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).
26. 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.
27. 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.
28. For the following miscellaneous items: artificial insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-covered services; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods provision; health club memberships, unless otherwise covered; home test kits, unless required by *applicable law*; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *rehabilitation* services for the enhancement of job, athletic, or recreational performance; routine or elective care outside the *service area*; treatment of spider veins; transportation expenses, unless specifically described in this *policy*.
29. Diagnostic testing, laboratory procedures screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
30. For court ordered testing or care unless *medically necessary*.
31. For a *member's illness* or *injury* which is caused by the acts or omissions of a *third party*, we have a right of recovery for any benefits paid in excess.
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 *surrogate* resulting from the *pregnancy*; or
j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*.

Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except where the child is the adoptive child of insureds possessing an active *policy* with us and/or the child possesses an active *policy* with us at the time of birth.

33. For any medicinal and recreational use of cannabis or marijuana.
34. Any non-*medically necessary* court ordered care for a medical/surgical or mental health/*substance use disorder* diagnosis, unless required by state law.
35. For expenses, services, and treatments related to private duty nursing in an inpatient location.
36. For expenses for services related to immunizations for travel and occupational purposes.
37. For expenses for services related to massage therapist.
38. For expenses, services, and treatments from a Naprapathic *specialist physician* for conditions caused by contracted, injured spasmed, bruised and/or otherwise affected myofascial or connective tissue.
39. For expenses, services, and treatments from a Naturopathic *specialist physician* for treatment of prevention, self-healing, and use of natural therapies.
40. For expenses for services related to dry needling.
41. For the treatment of infertility, except as expressly provided in this *policy*.
42. Assertive community treatment (ACT).
43. 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.

TERMINATION

Termination of Policy

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

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

Refund upon Cancellation

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

Reinstatement

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

Discontinuance

90-Day Notice: If we discontinue offering all policies issued on this form, for all residents of the state where you reside, we will provide a written notice to you at least 90 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 *policy*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

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

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 illness or injuries to you. Such illness or injuries are referred to as “Third Party Injuries.” “Third Party” includes any party responsible for payment of expenses associated with the care of treatment of Third-Party Injuries.

If this plan pays benefits under this *policy* to you for expenses incurred due to Third Party Injuries, then to the extent permissible by law Ambetter from Louisiana Healthcare Connections retains the right to repayment of the full cost of all benefits provided by this plan on your behalf that are associated with the Third-Party Injuries. Ambetter from Louisiana Healthcare Connections’ rights of recovery apply to any recoveries made by or on your behalf from the following 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 you for injuries resulting from an accident or alleged negligence.

By accepting benefits under this plan to the extent permissible by law, you specifically acknowledge Ambetter from Louisiana Healthcare Connections’ right of subrogation. When this plan pays health care benefits for expenses incurred due to Third Party Injuries, Ambetter from Louisiana Healthcare Connections shall be subrogated to your right of recovery against any party to the extent of the full cost of all benefits provided by this plan. Ambetter from Louisiana Healthcare Connections may proceed against any party with or without your consent. However, Ambetter from Louisiana Healthcare Connections’ right of subrogation is subordinate to your right to be full compensated for your damages, and Ambetter from Louisiana Healthcare Connections is obligated to share in the legal expenses incurred in any recovery.

By accepting benefits under this plan to the extent permissible by law, you also specifically acknowledge Ambetter from Louisiana Healthcare Connections’ right of reimbursement. This right of reimbursement attaches when this plan has paid benefits due to Third Party Injuries and you or your representative has recovered any amounts from a Third Party. By providing any benefit under this *policy*, Ambetter from Louisiana Healthcare Connections is granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by this plan. Ambetter from Louisiana Healthcare Connections right of reimbursement is cumulative with and not exclusive of Ambetter from Louisiana Healthcare Connections subrogation right and Ambetter from Louisiana Healthcare Connections may choose to exercise either or both rights of recovery. However, like Ambetter from Louisiana Healthcare Connections’ right of reimbursement is also subordinate to your right to be full compensated for your damages, and Ambetter from Louisiana Healthcare Connections is obligated to share in the legal expenses incurred in any recovery.

By accepting benefits under this plan, you or your representatives further agree to the extent permissible by law to:

1. Notify us promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party Injuries sustained by you;
2. Cooperate with us and do whatever is necessary to secure our rights of subrogation and reimbursement under this *policy*;
3. Give Ambetter from Louisiana Healthcare Connections a first-priority lien on any recovery, settlement, or judgment or other source 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);
4. Pay, as the first priority, from any recovery, settlement judgment, or other source of compensation, any and all amounts due to Ambetter from Louisiana Healthcare Connections as by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by Ambetter from Louisiana Healthcare Connections in writing; and
5. Do nothing to prejudice Ambetter from Louisiana Healthcare Connections rights as set forth above. 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 paid by the plan.
6. Serve as a constructive trustee for the benefits of this plan over any settlement or recovery funds received as a result of **Third-Party Injuries**.

Ambetter from Louisiana Healthcare Connections may recover full cost of all benefits paid by this plan under this *policy* without regard to any claim of fault on your part, whether by comparative negligence or otherwise. In the event you or your representative fail to cooperate with **Ambetter from Louisiana Healthcare Connections**, you shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by **Ambetter from Louisiana Healthcare Connections** in obtaining repayment**.**

COORDINATION OF BENEFITS

Applicability

1. This Coordination of Benefits ("COB") section applies to this plan when a *member* has health care coverage under more than one plan. "Plan" is defined below.
2. This section is intended to describe the Order of Benefit Determination Rules that govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100 percent of the total allowable expense.

Definitions (Applicable only to this section of the policy)

1. "Allowable expense" means any health care service or expense, including *deductible amounts*, *copayment amounts* or *coinsurance amounts*, that is covered in full or at least in part by any plan covering the person.
    a. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.
    b. An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.
    c. The following are examples of expenses that are not allowable expenses.
        i. If a person is confined in a private *hospital* room, the difference between the cost of a semi-private room in the *hospital* and the private room is not an allowable expense, unless one of the plans provides coverage for private *hospital* room expenses.
        ii. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.
        iii. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
    d. The following are examples of expenses that are allowable expenses.
        i. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans.
        ii. The amount of any benefit reduction by the primary plan because a *member* has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
2. "Closed Panel Plan" a plan that provides health benefits to *members* primarily in the

form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

3. "Coordination of Benefits or COB Provision" the part of the *policy* providing the health care benefits to which the COB provision applies, and which may be reduced because of the benefits of *other plans*. Any other part of the *policy* providing health care benefits is separate from this plan. A *policy* may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
4. "Custodial Parent"
    a. the parent awarded custody of a child by a court decree; or
    b. in the absence of a court decree, the parent with whom the child resides more than one half of the *calendar year* without regard to any temporary visitation.
5. "Order of Benefit Determination Rules" determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any *other plan* without considering any *other plan's* benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100 percent of the total allowable expense.
6. "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. If separate *policies* are used to provide coordinated coverage for members of a group, the separate *policies* are considered parts of the same plan and there is no COB among those separate *policies*.
    a. Plan includes:
        i. Group and non-group insurance contracts;
        ii. Health Maintenance Organization (HMO);
        iii. group and non-group coverage through closed panel plans;
        iv. Group-Type Contracts (whether insured or uninsured);
        v. the medical care components of long-term care contracts, such as skilled nursing care;
        vi. the medical benefits under group or individual automobile contracts;
        vii. Medicare or other governmental benefits, as permitted by law.
    b. Plan does not include:
        i. *hospital* indemnity coverage benefits or other fixed indemnity coverage;
        ii. accident only coverage;
        iii. specified disease or specified accident coverage;
        iv. limited benefit health coverage as defined by state law;
        v. school accident-type coverage except those enumerated in LSA-R.S. 22:1000 A.3C;
        vi. Benefits provided in long-term care insurance policies for non-medical services;
        vii. Medicare supplement policies;
        viii. a state plan under Medicaid; or
        ix. coverage under other federal government plans, unless permitted by law.

    Each *policy* for coverage under a or b, listed above, is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

Order of Benefit Determination Rules

1. When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:
    a. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any *other plan*.
        i. Except as provided in Paragraph (2) below, a plan that does not contain a Coordination of Benefits provision that is consistent with this section is always primary unless the provisions of both plans state that the complying plan is primary.
        ii. Coverage that is obtained by virtue of membership in a group that is designed to
        supplement a part of a basic package of benefits and provides that the supplementary coverage shall be excess to any other parts of the plan provided by the policyholder. Examples of these types of situations are major medical coverages that are superimposed over base plan *hospital* and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide non-network benefits.
    b. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that *other plan*.
2. Each plan determines its order of benefits using the first of the following rules that apply:
    a. Non-Dependent or Dependent Rule. The plan that covers the person other than as a dependent, for example as an employee, *member*, policyholder, *subscriber,* or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, *member*, policyholder, *subscriber,* or retiree is the secondary plan and the *other plan* is the primary plan.
    b. Dependent Child Covered Under More Than One Plan Rules. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:
        i. For a dependent child, whose parents are married or are living together, whether or not they have ever been married:
            (a) The plan of the parent whose birthday falls earlier in the *calendar year* is the primary plan; or
            (b) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
        ii. For a dependent child, whose parents are divorced or separated or not living together, whether or not they have ever been married:
            (a) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;
            (b) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage,

the provisions of Subparagraph (1) above shall determine the order of benefits;

(c) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) above shall determine the order of benefits; or

(d) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

i. The plan covering the custodial parent;
ii. The plan covering the *spouse* of the custodial parent;
iii. The plan covering the non-custodial parent; and then
iv. The plan covering the *spouse* of the non-custodial parent.

iii. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of Subparagraphs (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

iv. For a dependent child covered under the *spouse 's* plan:

(a) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a *spouse's* plan, the longer or shorter length in coverage rule applies.

(b) In the event the dependent child's coverage under the *spouse's* plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule above in Subparagraph (1) to the dependent child's parent(s) and the dependent's *spouse*.

(c) Active Employee or Retired or Laid-off Employee Rule. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the *other plan* does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule of Subparagraph (2) can determine the order of benefits.

(d) COBRA or State Continuation Coverage Rule. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, *member*, *subscriber,* or retiree or covering the person as a dependent of an employee, *member*, *subscriber,* or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the *other plan* does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule of

Subparagraph (2) determine the order of benefits.

(e) Longer or Shorter Length of Coverage Rule. The plan that covered the person as an employee, *member*, policyholder, *subscriber,* or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

(f) Fall-Back Rule. If none of the preceding rules determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In any event, this plan will never pay more than it would have paid had it been the primary plan.

Effects on the Benefits of this Plan

1. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan *deductible amount, copayment amount, coinsurance amount* and any amounts it would have credited to its *deductible amount* in the absence of other health care coverage. In any event, this plan will never pay more than it would have paid had it been the primary plan.
2. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the *member* and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:
    a. Determine its obligation to pay or provide benefits under its *policy*;
        i. Determine whether a benefit reserve has been recorded for the *member*; and
        ii. Determine whether there are any unpaid allowable expenses during that claim determination period.
3. If there is a benefit reserve, the secondary plan will use the *member's* benefit reserve to pay up to 100 percent of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.
4. If a *member* is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

You may request a copy in either paper form or electronic form of Appendix C, which provides an explanation for secondary plans on the purpose and use of the benefit reserve and how secondary plans calculate claims. A copy of Appendix C is also available on the Louisiana Department of Insurance's website at https://www.ldi.la.gov/docs/default-

source/documents/legaldocs/regulations/reg32appendixc.pdf?sfvrsn=24e14b52_0.

Summary

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language above, which determines your benefits.

1. Double Coverage
   It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers. When you are covered by more than one health plan, state law permits your insurers to follow a procedure called "Coordination of Benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses. Coordination of Benefits (COB) is complicated and covers a wide variety of circumstances. This is only an outline of some of the most common ones.

2. Primary or Secondary
   You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the "primary" or "secondary" benefit payer. The primary plan always pays first when you have a claim. Any plan that does not contain your state's COB rules will always be primary.

3. When this Plan is Primary
   If you or a family member are covered under another plan in addition to this one, we will be primary when:
   a. The claim is for your own health care expenses, unless you are covered by Medicare and both you and your *spouse* are retired;
   b. The claim is for your *spouse*, who is covered by Medicare, and you are not both retired;
   c. The claim is for the health care expenses of your child who is covered by this plan and:
      i) You are married and your birthday is earlier in the year than your *spouse's* or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the birthday rule;
      ii) You are separated or divorced, and you have informed us of a court decree that makes you responsible for the child's health care expenses; or
      iii) There is no court decree, but you have custody of the child.
4. Other Situations
   a. We will be primary when any other provisions of state or federal law require us to be. When we are the primary plan, we will pay the benefits in accordance with the terms of your *policy*, just as if you had no other health care coverage under any *other plan*.

b. We will be secondary whenever the rules do not require us to be primary. When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part, or all of the allowable expenses left unpaid, as explained below. An “Allowable Expense” is a health care service or expense covered by one of the plans, including *deductible amounts*, *copayment amounts* and *coinsurance amounts.*
    i) If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the *policy* calls for. Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) usually have contracts with their providers.
    ii) We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We will use any savings to pay the balance of any unpaid allowable expenses covered by either plan.
    iii) If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we will pay for those items as long as there is a balance in your benefit reserve, as explained below.
    iv) We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

c. Benefit Reserve
When we are secondary, we often will pay less than we would have paid if we had been primary. Each time we "save" by paying less, we will put that savings into a benefit reserve. Each family member covered by this plan has a separate benefit reserve. We use the benefit reserve to pay allowable expenses that are covered only partially by both plans. To obtain a reimbursement, you must show us what the primary plan has paid so we can calculate the savings. To make sure you receive the full benefit or coordination, you should submit all claims to each of your plans. Savings can build up in your reserve for one year. At the end of the year any balance is erased, and a fresh benefit reserve begins for each person the next year as soon as there are savings on their claims.

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give us any facts we need to pay the claim.

Facility of Payment

We may not pend, delay, or deny payment to a health care provider for rendered health care services solely on the basis of your failure to provide notice to us of the existence of an additional plan or lack thereof. A payment made under another plan may include an amount

that should have been paid under this plan. We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. To the extent, such payments are made; they discharge us from further liability. The term “payment made” includes providing benefits in the form of services, in which case the payment made will be deemed to be the reasonable cash value of any benefits provided in the form of services.

Right of Recovery

If the amount of the payments that we made is more than it should have paid under this COB section, we may recover the excess. We may get such recovery or payment from one or more of:

1. The persons we have paid or whom we have paid;
2. Insurance companies; or
3. Other organizations.

The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

CLAIMS

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

Proof of Loss
We must receive written *proof of loss* within 90 calendar days of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than 15 months from date services rendered will not be accepted.

Indemnity claims payable under this *policy* for any *loss* other than loss of time on account of disability will be paid *immediately* upon receipt of written proof of such *loss*. Subject to written *proof of loss*, accrued indemnity claims for loss of time on account of disability will be paid (insert period of payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid *immediately*.

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 also need to submit a copy of the *member* reimbursement claim form posted at Ambetter.LouisianaHealthConnect.com under “For Members-Forms and Materials.” Send all the documentation to us at the following address:

Ambetter from Louisiana Healthcare Connections
Attn: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

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

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

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

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

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

Time for Payment of Claims

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

Payment of Claims

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

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

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

Claims submitted for services received by a deceased *member* will be payable in accordance with the *beneficiary* designation and the provisions respecting such payments. If no such designation or provision is provided, claims will be payable to the estate of the *member*. Any other claims unpaid at the *member*'s death may, at our option, be paid to the *beneficiary*. All other claims will be payable to the *member* or to the provider, at our option.

Foreign Claims Incurred for Emergency Care

Emergency services are *covered service* 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.LouisianaHealthConnect.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 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.

Custodial Parent

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

Upon request by the custodial parent, we will:

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

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

Physical Examination

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 one year after the date *proof of loss* is required.

GRIEVANCE, APPEAL AND EXTERNAL REVIEW PROCEDURES

Internal Procedures

Grievance

Ambetter from Louisiana Healthcare Connections has a *grievance* procedure which allows the *member* the opportunity to resolve the *member's* issues and *complaints*. The process is voluntary and is available for review of the policy, quality of care or quality of service issues that affect the *member*. The *grievance* process does not apply to *complaints* based solely on the basis that the policy does not cover the service or limits benefits for the health care service in question, provided that the exclusion of the specific service requested is clearly stated in the *policy.*

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

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

Filing a Grievance

Grievances may be requested by a *member* or the *member's authorized representative*. *Grievances* may be filed orally by calling Member Services or in writing by mailing us a letter or the Grievance and Appeal Form from our website to:

Ambetter from Louisiana Healthcare Connections
PO Box 10341
Van Nuys, CA 91410
Fax: 1-833-886-7956

A *member* or the *member's authorized representative* has the right to submit written comments, documents, records, and other information relating to the claim for benefits, and the right to review the claim file and to present evidence and testimony as part of the internal review process.

Applicability/Eligibility

An eligible grievant is:

1. A *member*;
2. A person authorized (orally or in writing) to act on behalf of the *member*. **Note:** Written *authorization* is not required; however, if received, we will accept any written expression of *authorization* without requiring specific form, language, or format;
3. In the event the *member* is unable to give consent: a *spouse*, family member, or the treating provider.

Acknowledgement

Within 5 business days of receipt of a standard *grievance*, a written acknowledgment to the *member* or the *member's authorized representative* confirming receipt of the *grievance* must be delivered or deposited in the mail. In urgent claim situations requiring expedited handling, we will respond within 72 hours of receipt; and in situations involving concurrent care review, we will respond within 24 hours of receipt. Any verbal notifications will be followed up with a written document within 3 calendar days.

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

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

Resolution Timeframes

We will issue a written decision, in clear terms, to the *member* and *authorized representative*, if applicable, within 30 calendar days receipt of a standard non-expedited *grievance* or within 72 hours in urgent situations requiring expedited review. In general, Ambetter from Louisiana Healthcare Connections may seek member's approval to extend the time for providing a decision for 14 calendar days after the expiration of the initial period, or if the plan determines that such an extension is necessary for reasons beyond the control of the plan. There is no provision for extensions in the case of claims involving urgent care or expedited appeals.

Right to Participate

A *member* or the *member's authorized representative*, who has filed a *grievance* has the right to submit comments to the Grievances and Appeals Department. The *member* or *authorized representative* is entitled to request a copy of documentation reviewed by the Grievances and Appeals Department in making its determination.

Written Grievance Response

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

Our written decision to the *member* must include:

1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *grievance;*
3. A written description of position titles of the persons involved in making the decision;
4. A clear explanation of the decision;

5. A statement that the *member* is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *member 's* claim for benefits; and
6. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse determination*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse determination* and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the *member* upon request.

Appeals

When we deny a claim for a treatment or service, a claim for plan benefits the *member* has already received (*post-service claim* denial) or we deny the *member's* request to authorize treatment or service (pre-service denial), our decision is known as an *adverse determination*. The *member*, their *physician* or *authorized representative* can request an *appeal* of our decision. If we rescind the *member's* coverage or deny the *member's* application for coverage, the *member*, their *physician,* or *authorized representative* may also *appeal* our decision. When we receive an *appeal*, we are required to review our own decision.

Filing an Appeal

Appeals may be filed verbally by calling Member Services or in writing by completing the Grievance and Appeal Form from our website or sending a written *appeal* along with copies of any supporting documents and mailed or faxed to:

Ambetter from Louisiana Healthcare Connections
PO Box 10341
Van Nuys, CA 91410
Fax: 1-833-886-7956

We may follow up via telephone to verbal appeal requests to request additional information to help complete the appeal.

Time Limits for Filing an Appeal

The *member* or *authorized representative* must file the internal *appeal* within 180 calendar days of the receipt of the notice of denial (an *adverse determination*). Failure to file within this time limit may result in the company's declining to consider the *appeal*.

Applicability/Eligibility

An eligible appellant is:

1. A *member;*
2. Person authorized to act on behalf of the *member*. **Note:** Written *authorization* is required;
3. In the event the *member* is unable to give consent: a *spouse*, family member, or the treating provider; or
4. In the event of an *expedited appeal*: the person for whom the insured has verbally given *authorization* to represent the appellant.

Acknowledgement

Within 5 business days of receipt of an *appeal*, a written acknowledgment to the *member*, the provider or the *member's authorized representative* confirming receipt of the *appeal* must be delivered or deposited in the mail.

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

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

Resolution Timeframes

Appeals will be resolved, and we will notify the *member* in writing with the *appeal* decision within the following timeframes:

1. *Post-service claim*: within 60 calendar days after receipt of the request for internal *appeal*; or
2. *Pre-service claim*: within 30 calendar days after receipt of the request for internal *appeal*.
3. *Urgent or expedited internal appeals*: within 72 hours after receipt of the request for an expedited appeal.

In general, Ambetter from Louisiana Healthcare Connections may seek *member's approval* to extend the time for providing a decision for 14 calendar days after the expiration of the initial period, or if the plan determines that such an extension is necessary for reasons beyond the control of the plan. There is no provision for extensions in the case of claims involving urgent care or *expedited appeals*.

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

1. The *member* will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The plan will give the *member* a reasonable amount of time to respond to the new information before making a determination, without allowing such time to delay the contractual timeframe for resolution; or
2. The *member* will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer. The plan will give the member a reasonable amount of time to respond to the new information before making a

determination, without allowing such time to delay the contractual timeframe for resolution.

Expedited Appeal

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

An *expedited appeal* means an *appeal* where any of the following applies:

1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the *member* or the ability of the *member* to regain maximum function.
2. In the opinion of a provider with knowledge of the *member's* medical condition, the *member* is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *appeal*.

If the *expedited appeal* involves an *adverse determination* with respect to a concurrent review of an urgent care request, the service shall be continued until the *covered person* or *covered person's authorized representative* has been notified of the determination or until the health care provider determines that the urgent care is no longer appropriate or necessary.

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

Simultaneous Expedited Appeal and External Review

The *member* or *authorized representative*, may request an *expedited appeal* and an expedited external review (see External Review provision) if both the following apply:

1. The *member* filed a request for an *expedited appeal*; and
2. After a *final adverse determination*, if any of the following apply:
    a. The *member's* treating *physician* certifies that the *adverse determination* involves a medical condition that could seriously jeopardize the *member's life or health*, or would jeopardize the *member's* ability to regain maximum function, if treated after the timeframe of a standard external review;
    b. The *final adverse determination* concerns an admission, availability of care, continued stay or health care service for which the *member* received emergency services, but has not yet been discharged from a facility.
    c. The *final adverse determination* involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is *experimental or investigational* and the *covered person's* treating *physician* certifies in writing that any delay in *appealing* the *adverse determination* may pose an imminent threat to the *covered person's* health, including but not limited to severe pain, potential *loss* of life, limb, or major bodily function, or the immediate deterioration of the health of the *covered person*.

Right to Participate

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

Continuing Coverage

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

Cost and Minimums for Appeals

There is no cost for the *member* to file an *appeal* and there is no minimum amount required to be in dispute.

Rescission of Coverage

If the plan rescinds the *member's* coverage, the *member* may file an *appeal* of that determination. The plan cannot terminate a *member's* benefits until the *member's appeal* rights have been exhausted. Since a rescission means that no coverage ever existed, if the plan's decision to rescind is upheld, the *member* will be responsible for payment of all claims for health care services.

Emergency Medical Services

If the plan denies a claim for an *emergency medical service*, the *member's appeal* will be handled as an *expedited appeal*. The plan will advise the *member* at the time it denies the claim that the *member* can file an *expedited appeal*. If the *member* has filed for an *expedited appeal*, the *member* may also file for an expedited external review (see 'Simultaneous urgent claim, *expedited appeal* and external review").

Written Appeal Response

Appeal response letters will be written in a manner to be understood by the *member* and the notification shall include the specific reasons for the denial, determination, or initiation of disenrollment.

Our written decision (for an *adverse determination appeal*) will include:

1. The disposition of and the specific reason or reasons for the decision in clear terms and the medical rationale for the decision, if applicable
2. Any corrective action taken on the *appeal*;
3. The titles and qualifying credentials of the persons involved in making the decision;
4. A statement of the reviewer's understanding of the issues;
5. Reference to the evidence or documentation used as the basis for the decision
6. Reference to the specific plan or *policy* provision on which the determination is based;

7. A statement that the *member* is entitled to receive, upon request and free of charge, reasonable access to and, copies of all documents, records, and other information relevant to the *member's* issue;
8. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse determination*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse determination* and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the *member* upon request;
9. If the *adverse determination* is based on *medical necessity* or *experimental or investigational* treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the *member's* medical circumstances or a statement that such explanation will be provided free of charge upon request;
10. A description of the procedures for obtaining an external review of the *final adverse determination*; and
11. If applicable:
    a. Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse determination*;
    b. The date of service;
    c. The health care provider's name;
    d. The claim amount;
    e. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
    f. Ambetter from Louisiana Healthcare Connections' denial code with corresponding meaning;
    g. A description of any standard used, if any, in denying the claim;
    h. A description of the external review procedures, if applicable;
    i. The right to bring a civil action under state or federal law;
    j. A copy of the form that authorizes Ambetter from Louisiana Healthcare Connections to disclose protected health information, if applicable;
    k. That assistance is available by contacting the Louisiana Department of Insurance, if applicable; and
    l. A culturally linguistic statement based upon the *member's* county or state of *residence* that provides for oral translation of the *adverse determination*, if applicable.

Complaints received from the State Department of Insurance

The commissioner may require us to treat and process any *complaint* received by the State Department of Insurance by, or on behalf of, a *member* as a *grievance* as appropriate. We will process the State Department of Insurance *complaint* as a *grievance* when the commissioner provides us with a written description of the *complaint*.

External Review

An external review decision is binding on us. An external review decision is binding on the *member* except to the extent the *member* has other remedies available under applicable federal or state law. We will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility

The external review procedures apply to:

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

After exhausting the internal *appeal* process, the *member* has four (4) months to make a written request to the Grievances and Appeals Department for an external review after the date of receipt of our internal response.

1. If Ambetter from Louisiana Healthcare Connections has not issued a written decision to the *member* or his *authorized representative* within 30 calendar days following the date the *member* or *authorized representative* files the *appeal* and the *member* or *authorized representative* has not requested or agreed to a delay, the *member* or *authorized representative* may file a request for external review and shall be considered to have exhausted the health insurance issuer's internal claims and *appeals* process.
2. The internal *appeal* process must be exhausted before the *member* may request an external review unless the *member* files a request for an expedited external review at the same time as an internal *expedited appeal* or we either provide a waiver of this requirement or fail to follow the *appeal* process;
3. A *member* may make a request for an expedited external review with the plan at the time the *member* receives:
    a. An *adverse determination* if the determination involves a medical condition of the *member* for which the timeframe for completion of an internal *appeal* would seriously jeopardize the life or health of the *member* or would jeopardize the *member's* ability to regain maximum function and the member has filed a request for an internal *expedited appeal*; and
    b. A *final internal adverse determination*, if the *member* has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the *member* or would jeopardize the *member's* ability to regain maximum function, or if the *final internal adverse determination* concerns an admission, availability of care, continued stay, or health care item or service for which the *member* received *emergency* services, but has not been discharged from a facility; and
4. *Members* may request an expedited external review at the same time the internal *expedited appeal* is requested if:
    a. if the *member* has a medical condition in which the time frame for completion of an expedited review of the *appeal* involving an *adverse determination* would seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function; or
    b. if the *adverse determination* involves a denial of coverage based on a determination that the recommended or requested health care service or

treatment is *experimental or investigational* and the *member's* treating *physician* certifies in writing that any delay in *appealing* the *adverse determination* may pose an imminent threat to the *member's* health, including but not limited to severe pain, potential *loss* of life, limb, or major bodily function, or the immediate deterioration of the health of the *covered person*.

5. Upon receipt of a request for an expedited external review at the same time the internal *expedited appeal* is requested, the independent review organization conducting the external review will determine whether the *member* is required to complete the expedited *appeal* process with us first before it conducts the expedited external review.

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

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

External Review Process

1. We have five business days (*immediately* for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether all of the following have been met:
    a. The individual was a *covered person* at the time the item or service was requested or, in the case of a retrospective review, was a *covered person* in the health benefit plan at the time the health care service was provided;
    b. The health care service is the subject of an adverse determination or a final adverse determination;
    c. The *member* has exhausted the internal *appeal* process, unless the *covered person* is not required to exhaust the health insurance issuer's internal claims and *appeals* process; and
    d. The *member* has provided all of the information and forms required to process an external review.
2. Within five business days (*immediately* for expedited) after completion of the preliminary review, we will notify the commissioner and the *member* and, if applicable, the *authorized representative* in writing whether:
    a. The request is complete.
    b. The request is eligible for external review.
    c. If the request is not complete, inform the *covered person* and, if applicable, the *authorized representative* what information or materials are needed to make the request complete.
    d. If the request is not eligible for external review, inform the *covered person* and, if applicable, the *authorized representative* the reasons for its ineligibility. The *covered person* and, if applicable, the *authorized representative* may *appeal* our initial determination to the commissioner of insurance.
3. We will notify the commissioner when a request is eligible for external review by submitting a request for assignment of an IRO through the Department of Insurance's

website. If the request is determined not complete a notice shall be provided stating with specificity the information or materials needed to make the request complete. If a form is required by us has not been completed, we shall include in the notice a copy of the form, and copies of any materials submitted by the member or, if applicable, his/her *authorized representative* that could reasonably be interpreted as pertaining to the same subject matter or purpose of the form. Any notice or form required to be provided may be provided electronically on the department's website. Upon notification, the commissioner shall do the following:

   a. Randomly assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner to conduct the external review and notify us of the name of the assigned IRO.
   b. Within one (1) business day, send written notice to the *covered person* and, if applicable, the *authorized representative*, of the request's eligibility and acceptance for external review and the identity and contact information of the assigned IRO. The notice will also state *covered person* and, if applicable, the *authorized representative* may submit in writing to the assigned IRO, within five business days following the date of receipt of the notice, any additional information that the IRO should consider when conducting the external review. The IRO shall be authorized but not required to accept and consider additional information submitted after five business days.

4. Within five business days after the date of assignment of the IRO, we must provide the documents and any information considered in making the *adverse determination* to the IRO.
   Note: For expedited, after assignment of the IRO, we must provide the documents and any information considered in making the *adverse determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method;
5. If a health insurance issuer or its utilization review organization fails to provide the documents and information within the time frame specified, the assigned IRO may terminate the external review process and make a decision to reverse the adverse determination or the final adverse determination. This paragraph shall not apply if issuer's failure to provide documents or information is due to the *member's* failure to provide a signed form authorizing the issuer to proceed with an external review or to release the *member's* personal health information to the IRO as required by federal law;
6. Upon receipt of any information submitted by the *member*, the IRO must forward the information to us within one (1) business day;
7. Upon receipt of the information, we may reconsider our determination. If we reverse our *adverse determination*, we must provide written notice of the decision to the *member* and the IRO within one (1) business day after making such decision. The external review would be considered terminated;
8. Within one (1) business day after making the decision to reverse an *adverse determination* or *final adverse determination*, we will notify the *covered person*, if applicable, the *authorized representative*, the assigned IRO, and the commissioner in writing of our decision. The assigned IRO will terminate the external review upon receipt of the notice sent by us.
9. Within 45 calendar days for external review requests related to medical necessity determinations or 41 calendar days for external review requests related to services denied as *experimental or investigational* (as expeditiously as medical condition or circumstances requires, but in no event more than 72 hours for expedited medical

necessity denials and as soon as possible, but no longer than eight days for expedited *experimental or investigational* denials) 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 determination* to the *covered person*, if applicable, the *authorized representative*, the commissioner, and to us; and

10. Upon receipt of a notice of a decision by the IRO reversing the *adverse determination* or *final adverse determination*, we will *immediately* approve the coverage or payment that was the subject of the *adverse determination* or *final adverse determination.*

Expedited External Review

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

1. An *adverse determination* if both of the following apply:
    a. If the determination involves a medical condition of the *member* for which the timeframe for completion of an internal *expedited appeal* would seriously jeopardize the life or health of the *member* or would jeopardize the *member's* ability to regain maximum function; and
    b. The *covered person* or *authorized representative* has filed a request for an expedited review for an *appeal* involving an *adverse determination*.
2. A *final adverse determination* if either of the following applies:
    a. The *covered person* has a medical condition in which the time frame for completion of a standard external review would seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function.
    b. The *final adverse determination* concerns an admission, availability of care, continued stay, or health care service for which the *covered person* received emergency services, but has not been discharged from a facility.

An expedited external review will not be provided for retrospective *adverse determinations* or retrospective *final adverse determinations*.

Members may request assistance with all levels of the *appeal* process from the Louisiana Department of Insurance's office of consumer advocacy. The office of consumer advocacy may be contacted at:

Office of Consumer Advocacy
Louisiana Dept. of Insurance
P. O. Box 94214
Baton Rouge, LA 70804-9214
1-225-342-5900 or 1-800-259-5300

The *member* may also view their *grievance* and *appeal* information in their Member Secure Portal.

GENERAL PROVISIONS

Entire Policy

This *policy,* the enrollment application, expressing the entire money and other consideration for *coverage*, the *Schedule of Benefits*, and any amendments and/or riders make up the entire *policy* between you and us*.* No agent may:

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

Non-Waiver

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

Rescissions

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

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

In such event, we will give you 30 calendar days’ advance written notice and will include the reason for rescission. Rescission could be retroactive to the *effective date* of coverage.

Repayment for Fraud, Misrepresentation or False Information

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

Change in Premium Amount

1. This *policy* will expire December 31, 2024. This *policy* is renewable at your option for the *policy year* beginning January 1, 2025. Any renewal of this *policy* for the *policy year* that begins on January 1, 2025, will be subject to premium changes based on the rates that apply.

2. Except as provided in the following paragraph, we will give you 45 calendar days written notice of a premium change, at your last address shown in our records. Any change in premium will become effective on the date specified in the notice. If you continue to pay your premiums, you show that you accept the change.
3. Premiums are guaranteed for the *policy year*. However, we reserve the right to change premiums more often due to a change in the extent or nature of the risk that was not previously considered in the rate determination process at any time during the life of the policy. This risk includes the addition of a newly *covered person*. Additionally, we reserve the right to change the premium if you request a change in benefits from that which was in force at the time of the last rate determination.
4. If your age was misstated, any amount payable or any indemnity accruing under this *policy* will be such as the premium paid would have purchased at the correct age. A clerical error will not void insurance which should be in force, nor will it continue insurance which should have ended.
5. If non-tobacco premiums are charged when tobacco premiums should have been charged, we may retroactively adjust the premium and collect the appropriate premium.

Applicable Law and Conforming Policy

This *policy* will be governed and construed according to the laws and regulations of the State of Louisiana except when preempted by federal law. This *policy* is not subject to regulation by any state other than the State of Louisiana. This *policy* will conform to the *Essential Health Benefits* package and requirements. If any provision of this *policy* is in conflict with *applicable laws* on this *policy's effective date*, the *policy* is changed to conform to the minimum requirements of the *applicable law*. Any legal action filed against us must be filed in the appropriate court in the State of Louisiana.

Extension of Time Limitations

If any limitation of this policy with respect to giving notice of claim, furnishing *proof of loss*, or bringing any action on this policy is less than that permitted by law of the state, district, or territory in which the insured resides at the time this policy is issued, such limitation is hereby extended to agree with the minimum period permitted by such law.

Continuity of Care

You have the right to continuity of care that applies to the following provisions and subject to consent of the treating provider:

1. If *you* have been diagnosed with a *life-threatening illness*.
2. If *you* have been diagnosed with *serious acute condition*.
3. If *you* have been diagnosed as being in a high-risk *pregnancy* or are past the 24th week of *pregnancy*, *you* can continue receiving *covered services* through delivery and postpartum care related to the *pregnancy* and delivery.
4. If *you* are currently within an ongoing course of treatment for a health condition for which a treating provider attests that discontinuing care by that provider would worsen the condition or interfere with anticipated outcomes.

The provisions of continuity of care do not apply if any of the following occurs:

1. The reason for termination of a provider's contractual agreement is a result of documented reasons relative to quality of care, or the suspension, revocation, or

applicable restriction of the license to practice in Louisiana by the Louisiana State Board of Medical Examiners.
2. You voluntarily choose to change providers.
3. You move outside of the geographic *service area* of the provider.
4. Your chronic condition only requires routine monitoring and is not in an acute phase of the condition.

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 Ambetter.LouisianaHealthConnect.com or call Member Services.

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

Language

If you do not speak or understand the language in your area, you have the right to an interpreter. For language assistance, please visit: Ambetter.LouisianaHealthConnect.com.

Women's Health and Cancer Rights Act of 1998

Surgical services for breast reconstruction and for post-operative prostheses incidental to a *medically necessary* mastectomy are covered. Coverage includes:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications for all stages of mastectomy, including lymphedemas and at least four external postoperative prostheses subject to all of the terms and conditions of the policy.

STATEMENT OF NON-DISCRIMINATION

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

Ambetter from Louisiana Healthcare Connections Inc.:

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

If you need these services, contact Ambetter from Louisiana Healthcare Connections Inc. at 1-833-635-0450 (TTY 711).

If you believe that Ambetter from Louisiana Healthcare Connections Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a *grievance* with: Ambetter from Louisiana Healthcare Connections Inc., Attn: Appeals and Grievances PO Box 10341 Van Nuys CA, 91410, 1-833-635-0450 (TTY 711), Fax 1-833-886-7956. You can file a *grievance* by mail, fax, or email. If you need help filing a *grievance*, Ambetter from Louisiana Healthcare Connections Inc. is available to help you. You can also file a civil rights *complaint* with the U.S Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD 711).

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

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Louisiana Healthcare Connections, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-635-0450 (TTY 711).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Louisiana Healthcare Connections, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez-le 1-833-635-0450 (TTY 711).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Louisiana Healthcare Connections, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-833-635-0450 (TTY 711).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Louisiana Healthcare Connections 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-833-635-0450 (TTY 711)。
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حولAmbetter from Louisiana Healthcare Connections، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-833-635-0450 (TTY 711).
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Louisiana Healthcare Connections, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-833-635-0450 (TTY 711)**.**
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Louisiana Healthcare Connections에 관해서 질문이 있다면 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-833-635-0450 (TTY 711) 번으로 전화하십시오.
Portuguese:	Se você ou alguém que estiver a ajudar tiver dúvidas sobre a Ambetter from Louisiana Healthcare Connections, tem o direito de obter ajuda e informações no seu idioma gratuitamente. Para falar com um intérprete, ligue para 1-833-635-0450 (TTY 711).
Laotian:	ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ ມີຄໍາຖາມກ່ຽວກັບ Ambetter from Louisiana Healthcare Connections, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ ໃຫ້ໂທຫາ 1-833-635-0450 (TTY 711).
Japanese:	Ambetter from Louisiana Healthcare Connections について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-833-635-0450 (TTY 711) までお電話ください。
Urdu:	اگر Ambetter from Louisiana Healthcare Connections کے بارے میں آپ کے، یا جن کی آپ مدد کر رہے ہیں، ان کے سوالات ہوں تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی مترجم سے بات کرنے کے لیے 1-833-635-0450 (TTY 711) پر کال کریں۔
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Louisiana Healthcare Connections hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-833-635-0450 (TTY 711) an.
Persian:	اگر شما، یا کسي که به او کمک مي کنيد سؤالي در مورد Ambetter from Louisiana Healthcare Connections داريد، از اين حق برخورداريد که کمک و اطلاعات را بصورت رايگان به زبان خود دريافت کنيد. براي صحبت کردن با مترجم با شماره 1-833-635-0450 (TTY 711) تماس بگيريد.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Louisiana Healthcare Connections вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-833-635-0450 (TTY 711).
Thai:	หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีคำถามเกี่ยวกับ Ambetter from Louisiana Healthcare Connections ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข 1-833-635-0450 (TTY 711).