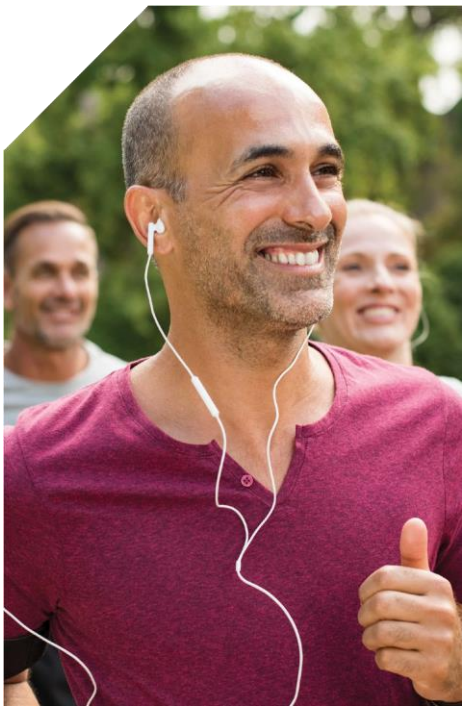
ambetter HEALTH™



# 2025 EVIDENCE OF COVERAGE

## AMBETTER HEALTH SOLUTIONS

Underwritten by Celtic Insurance Company

AmbetterHealth.com

37710MS011-2025

# Ambetter Health Solutions
## Issued and underwritten by Celtic Insurance Company

Home Office: 1020 Highland Colony Parkway, Suite 502, Ridgeland, MS 39157
Individual Member Contract

In this *contract,* the terms *"*you*"* or *"*your*", "*yours*"* will refer to the *member* and/or any dependents enrolled in this *contract*. The terms *"*we*," "*our*,"* or *"*us*"* will refer to Ambetter Health Solutions.

## AGREEMENT AND CONSIDERATION

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

## GUARANTEED RENEWABLE

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

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

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

At least 75 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 *contract* or a change in a *member's* health. While this *contract* is in force, we will not restrict coverage already in force. If we discontinue offering and decide not to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 90 calendar days prior to the date that we discontinue coverage.

This *contract* contains *prior authorization* requirements. Please refer to your *Schedule of Benefits* and the *Prior Authorization* Section.

## TEN DAY RIGHT TO RETURN CONTRACT

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

Celtic Insurance Company

Kevin J. Counihan, President

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# INTRODUCTION

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

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

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

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

Ambetter Health operates under its legal entity, Celtic Insurance Company.

**How To Contact Us**
Ambetter Health
1020 Highland Colony Parkway, Suite 502, Ridgeland, MS 39157
Normal Business Hours of Operation 8:00 a.m. to 8:00 p.m. local time, Monday through Friday

Member Services 1-833-543-3145 (TTY 711)
Fax 1-877-941-8075
Emergency 911
24/7 Nurse Advice Line 1-833-543-3145 (TTY 711)

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

Our interpreter services are provided at no cost to you. We have representatives that speak Spanish and have medical interpreters to assist with languages other than English via telephone. An interpreter will not go to a p*rovider's* office with you. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation, or to request materials in Braille or large font.

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

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

You have the right to:

1. Participate with your provider and *medical practitioners* in decisions about your health care. This includes working on any treatment plans and making care decisions. You should know any possible risks, problems related to recovery, and the likelihood of success. You shall not have any treatment without consent freely given by you or your legally *authorized representative*. You will be informed of your care options.
2. Know who is approving and performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which you have coverage.
4. Be treated with respect and dignity.
5. Privacy of your personal health information, consistent with state and federal laws, and our policies.
6. Receive information or make recommendations, including changes, about our organization and services, our *network* of providers and *medical practitioners*, *hospitals,* other facilities, and your rights and responsibilities.
7. Make recommendations regarding our *member* rights and responsibilities policy.
8. Candidly discuss with your provider and *medical practitioners* appropriate and *medically necessary* care for your condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *PCP* about what might be wrong (to the level known), treatment and any known likely results. Your *PCP* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. You have a right to know about any costs you will need to pay. This should be told to you in words you can understand. When it is not appropriate to give you information for medical reasons, the information can be given to a legally *authorized representative*. Your provider will ask for your approval for treatment unless there is an emergency and your life and health are in serious danger.
9. Voice *complaint*s 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, providers, advance directive information, *authorizations*, benefit denials, *member* rights and responsibilities, and our other rules and guidelines. We will notify you at least 60 days before the *effective date* of the modifications. Such notices shall include the following:

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

You have the responsibility to:

1. Read this entire *contract*.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about your health that we or your *physician*s need in order to provide care. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your provider until you understand the care you are receiving.
4. Review and understand the information you receive about us. You need to know the proper use of *covered services*.
5. Show your *member* identification card and keep scheduled appointments with your provider

and call the provider's office during office hours whenever possible if you have a delay or cancellation.

6. Know the name of your assigned *PCP*. You should establish a relationship with your provider. You may change your *PCP* verbally or in writing by contacting 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 providers.
9. Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you. You should work with your PCP to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.
10. Follow all 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 notify the entity with which you enrolled.
13. Pay your monthly premiums on time and pay all *deductible amounts, copayment amounts*, or *coinsurance* amount at the time of service.
14. Notify us or the entity you enrolled with of any enrollment related changes that would affect your *contract*, such as: birth of a child, or adoption, marriage, divorce, adding/removing a dependent, *spouse*/domestic partner be-comes eligible under a different insurer, enrollment changes, address changes, or incarceration where *member cost share* would need to transfer from one contract to another contract.

# IMPORTANT INFORMATION

## Provider Directory

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

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

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

## Member Identification Card

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

Your *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 can answer many of your frequently asked questions. Our website has resources and features that make it easy to get quality care. Our website can be accessed at AmbetterHealth.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 your *PCP.*
10. Making your payment.

## Quality Improvement

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

1. Conducting a thorough check on providers when they become part of the provider *network*.

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

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

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

## Protection from Balance Billing

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

You may also contact 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*.

# DEFINITIONS

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

Wherever used in this *contract*:

***Acute rehabilitation*** is *rehabilitation* for patients who will benefit from an intensive, multidisciplinary *rehabilitation* program. Patients normally receive a combination of therapies such as physical, occupational and speech therapy as needed and are medically managed by specially trained *physicians*. *Rehabilitation* services must be performed for three or more hours per day, five to seven days per week, while the *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 payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit payments to apply to your premiums each month, up to the maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you are due, you will get the difference as refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax retu*rn.*

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

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

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

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

**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 plan. See *balance billing* and *balance billing* protections, and *non-network provider* definitions for additional information. If you are *balance billed* in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.

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

***Appeal*** means a *grievance* requesting the insurer to reconsider, reverse, or otherwise modify an *adverse benefit determination*, service, or claim.

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

***Applied behavior analysis*** *(ABA)* is 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*.

***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.

***Authorization*** or ***authorized*** *(*also ***prior authorization* or *approval)*** means our decision to approve the medical necessity or the appropriateness of care for an enrollee by the enrollee's *PCP* or provider. *Authorizations* are not a guarantee of payment.

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

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

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

***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 by a *network provider*, 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 the 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.

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

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

***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 at the sole option of us.

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

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

***Coinsurance amount*** means the percentage of *covered service expenses* that you are required to pay when you receive a service, after your *deductible* has been met, if applicable. *Coinsurance amounts* are listed in your *Schedule of Benefits*. Not all *covered services* have *coinsurance*.

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

***Complications of pregnancy*** means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

***Eligible child*** means the child of a 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 foster child placed in your custody.
4. A child placed with you for adoption; or
5. A child for whom legal guardianship has been awarded to you, your *spouse,* or domestic partner; or
6. A stepchild

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

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

1. For *network providers* (excluding Transplant Benefits): When a *covered service* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.
    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*.

For all other *covered services* received from a *non-network provider* for which any needed *authorization* is received from us, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full (you will not be billed for the difference between the negotiated fee and the provider's charge). If there is no negotiated fee agreed to by the provider with us, the *eligible expense* is 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 service*s 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 drug*s charged by that facility. If you are admitted to a *hospital* as a result of an *emergency condition*, you must notify us or verify that your *physician* has notified us of your admission within 48 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the *inpatient* setting is appropriate, and if appropriate, the number of days considered *medically necessary*. By contacting us, you may avoid financial responsibility for any *inpatient* care that is determined to be not *medically necessary* under your *contract*. If your provider does not contract with us, you may be financially responsible for any care we determine is not a *covered service* because it is not *medically necessary*. Care and treatment provided once you are *stabilized* is no longer considered *emergency services* under your *contract*. Continuation of care beyond what is needed to evaluate or *stabilize* your condition in an emergency will not be a *covered service* unless we authorize the continuation of care and it is *medically necessary*.

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

***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 provider with knowledge of the claimant's medical condition, the claimant is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*.
3. A provider 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* according to the provider's research protocols.

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

***Extended care facility* (*ECF*)** Means a facility that is primarily engaged in providing comprehensive post-acute *hospital* and *inpatient* rehabilitative care, and is licensed by the designated government agency to provide such services. The definition of an *ECF* does not include institutions that provide only minimal, custodial, assisted living, independent living communities, extended nursing homes, residential care homes, ambulatory or part-time care services, or institutions that primarily provide for the care and treatment of *behavioral health*, or pulmonary tuberculosis.

***External independent review*** means an external third-party binding review by an Independent Review Organization (IRO) after the plan's internal *grievance*/*appeal* process has been exhausted, as

applicable, and defined by the state regulations for all medical necessity denials. The request may be concurrent in the case of expedited *appeals*.
***Generally accepted standards of medical practice*** are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials.

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

***Grievance*** means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing in any form to the insurer by, or on behalf of, a claimant including any of the following:

1. Provision of services.
2. Determination to rescind a *contract*.
3. Determination of a diagnosis or level of service required for evidence-based treatment of *autism spectrum disorders*.
4. Claims practices.

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

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

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

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

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

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

1. Operates pursuant to law as a *home health care agency*.
2. Is regularly engaged in providing *home health care* under the regular supervision of a registered nurse.
3. Maintains a daily medical record on each patient; and
4. Provides each patient with a planned program of observation and treatment by a provider, in accordance with existing 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 *member*s 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 providers available at all times.
5. Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or in facilities available to it on a prearranged basis; and
6. Is not primarily a long-term care facility; an *extended care facility*, nursing, rest, *custodial care*, or convalescent home; a halfway house, transitional facility, or *residential treatment facility;* a facility for wilderness or outdoor programs; or a similar establishment.

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

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

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

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

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

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

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

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

***Loss of minimum essential coverage*** means in the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of *loss* of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). *Loss* of eligibility does not include a *loss* due to the

failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). *Loss* of eligibility for coverage includes, but is not limited to:

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

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

***Maximum out-of-pocket amount*** means the maximum amount a *member* must pay towards *covered service*s 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 provider, nurse anesthetist, provider's assistant, nurse practitioner, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *contract:* speech therapist, occupational therapist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, emergency medical technician, social worker, family counselor, marriage counselor, child counselor, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*,

a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

1. Is consistent with the symptoms or diagnosis.
2. Is provided according to generally accepted medical practice standards.
3. Is not *custodial care*.
4. Is not solely for the convenience of the provider 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 *contract* holder. A *member* must either be named in the enrollment application, or we must agree in writing to add them as a *dependent member*.

***Mental health disorder*** means a condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

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

***Necessary medical supplies*** means medical supplies that are:

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

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

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

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

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

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

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

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

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

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

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

***Other plan*** means any plan or contract 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 contract*s, self-insured group plans, prepayment plans, and Medicare when the *member* is enrolled in Medicare. *Other plan* will not include Medicaid.

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

***Outpatient services*** means both facility, ancillary, and professional charges when given as an outpatient at a *hospital*, alternative care facility, retail health clinic, or other *physician* 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 provider*s* 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.

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

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

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

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

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

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

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

***Prescription drug deductible amount*** means the amount of *covered expenses*, shown in your *Schedule of Benefits*, if applicable, that must actually be paid during any *calendar year* before any *prescription drug* benefits are payable. The family *prescription drug deductible amount* is two times the individual *prescription drug deductible amount*. For family coverage, once a *covered person* has met the individual *prescription drug deductible amount*, any remaining family *prescription drug deductible amount* can be met with the combination of any one or more covered 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 (PCP)*** means a *physician* who gives or directs health care services for you. *PCP*'s include internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), *Physician* Assistants (PA), obstetrician gynecologist (ob-gyn) and pediatricians or any other practice allowed by the plan. A *PCP* supervises, directs, and gives initial care and basic medical services to you and is in charge of your ongoing care.

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

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

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

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

***Qualified health plan*** 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 therapy. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment under a *pain management program*.

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

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

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

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

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

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

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

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

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

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

***Schedule of benefits*** means a summary of the *deductible amounts*, *copayment amounts*, *cost sharing percentages*, maximums and other limits that apply when you receive *covered services*.

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

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

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

***Skilled nursing facility*** **(*SNF*)** means a facility (which meets specific regulatory certification requirements) that primarily provides *inpatient* skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital. This is a level of care that requires the daily involvement of skilled

nursing or rehabilitation staff. Examples of skilled nursing facility care include, but not limited to intravenous injections and physical therapy.

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

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

***Spouse*** means the person to whom you are lawfully married.

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

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

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

***Substance use disorder*** means a condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders.*

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

***Surrogate*** means an individual carrier 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.

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

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

***Terminal illness counseling*** means counseling of the *immediate family* of a *terminally ill* person for the purpose of teaching the *immediate family* to care for and adjust to the *illness* and impending death of the *terminally ill* person.
***Terminally ill*** means a *physician* has given a prognosis that a *member* has six months or less to live.

***Third party*** means a person or other entity that is or may be obligated or liable to the *member* for payment of any of the *member's* expenses for *illness* or *injury*. The term *"third party"* includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; an underinsurance or uninsurance carrier; and an insurance company.

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

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

***Unproven service(s)*** means services, including medications that are determined not to be effective for treatment of the medical condition 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, *care management*, discharge planning, or retrospective review.

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

# DEPENDENT MEMBER COVERAGE

## Dependent Member Eligibility

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

1. The date you became covered under this *contract*.
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 application for this *contract* will be covered on your *effective date*.

## Coverage for a Newborn Child

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

Additional premium will be required to continue coverage beyond the 31st day after the date of birth. 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 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 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 calendar day after its birth, unless we have received notice by the entity that you have enrolled (either the Health Insurance Marketplace or us).

## 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 calendar 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 calendar day following *placement* of the child and we have received notification from the Health Insurance Marketplace. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on the 31st calendar day following *placement*, unless we have received both: (A) notification of the addition of the child from the Health Insurance 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.

## Adding Other Dependent Members

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

## Prior Coverage

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

If there is no prior coverage or no continuation of *Inpatient* coverage after the *effective date*, your Ambetter coverage will apply for covered benefits related to the *Inpatient* coverage after your *effective date*. We require you notify us within 2 calendar days of your *effective date* so we can review and authorize *medically necessary* services. If services are at a non-contracted *hospital*, claims will be paid at our *allowed amount*, and you may be billed for any balance of costs above our *allowed amount*.

# ONGOING ELIGIBILITY

## For All Members

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

1. The date that a *member* 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 *contract*.
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 *contract*, or any later date stated in your request.
4. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *contract* or the date that we have not received timely premium payments in accordance with the terms of this *contract*.
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 *contract*); 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 at www.healthcare.gov or 1-800-318-2596. If you enrolled through Ambetter, please 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*, coverage will terminate the thirty-first day of December the year that the *dependent* turns 26 years of age.

At the *dependent member's* request, eligibility will be continued past the age limit until the end of the month in which the *dependent member* reaches age 26 if the *dependent member*:

1. Is the natural child, stepchild, or adopted child of the *member*
2. Is a resident or a full-time student at an accredited higher education institution
3. Is not employed by an employer that offers any health benefit plan under which the *dependent member* is eligible for coverage; or
4. Is not eligible for coverage under Medicaid or Medicare.

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

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

## Open Enrollment

Each year there will be an open enrollment period for coverage. The open enrollment period begins November 1, 2024, and extends through January 15, 2025. *Qualified individuals* who enroll on or prior to December 15, 2024, will have an *effective date* of coverage on January 1, 2025.

## Special Enrollment Periods

In general, a *qualified individual* has 60 calendar days to report certain life changes, known as

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

1. A *qualified individual* or *dependent* experiences a *loss of minimum essential coverage*, non-*calendar year* group or individual health insurance coverage, *pregnancy*-related coverage, access to healthcare services through coverage provided to a pregnant enrollee's unborn child, or medically needed coverage.
2. A *qualified individual* gains a *dependent* or becomes a *dependent* through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order. In the case of marriage, at least one *spouse* must demonstrate having *minimum essential coverage* as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 calendar days preceding the date of marriage.
3. A *qualified individual* or *dependent*, who was not previously a citizen, national, or lawfully present individual gains such status; or who is no longer incarcerated or whose incarceration is pending the disposition of charges.
4. A *qualified individual's* enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or its instrumentalities as evaluated and are determined by the Health Insurance Marketplace.
5. An enrollee or *dependent* adequately demonstrates to the Health Insurance Marketplace that the plan in which he or she is enrolled substantially violated a material provision of its *contract* in relation to the enrollee.
6. A *qualified individual*, enrollee, or *dependent*, adequately demonstrates to the Health Insurance Marketplace that a material error related to plan benefits, *service area*, or premium influenced the *qualified individual's* or enrollee's decision to purchase the *QHP*.
7. An enrollee or *dependent* enrolled in the same plan is determined newly eligible or has a change in *eligibility* for *cost sharing reductions*.
8. A *qualified individual* or *dependent* who is enrolled in an eligible employer-sponsored plan is determined newly eligible for *advanced premium tax credits* based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-2(c)(3);
9. A *qualified individual*, enrollee, or *dependent* gains access to new *QHPs* as a result of a permanent move and had *minimum essential coverage* as described in 26 CFR 1.5000A–1(b) for one or more days during the sixty calendar days preceding the date of the permanent move.
10. A *qualified individual* or *dependent* who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a plan, or change from one plan to another one time per month.
11. A *qualified individual* or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by Health and Human Services (HHS), that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide.
12. A *qualified individual*, enrollee, or *dependent* is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B–2 and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment.
13. A *qualified individual* or *dependent* is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP) but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 calendar days after the qualifying event; or applies for coverage at the State Medicaid or CHIP agency

during the annual open enrollment period and is determined ineligible for Medicaid or CHIP after open enrollment has ended.

14. A *qualified individual* newly gains access to an employer sponsored Individual Coverage Health Reimbursement Arrangement (ICHRA) (as defined in 45 CFR 146.123(b)) or a Qualified Small Employer Health Reimbursement Arrangement (QSHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code).
15. At the option of the Health Insurance Marketplace, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a plan through the Health Insurance Marketplace following termination of enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for Health and Human Services (HHS) to verify his or her citizenship, status as a national, or lawful presence; or
16. A *qualified individual* or dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions or government subsidies completely cease.
17. A qualified individual or enrollee, or their dependent who is eligible for an advance premium tax credit, and whose household income is projected to be at or below 150 percent of the federal poverty level.

To determine if you are eligible and apply for a Special Enrollment Period, please visit Healthcare.gov and search for *"*special enrollment period*."* The Health Insurance Marketplace is responsible for all healthcare eligibility and enrollment decisions for *members* who enrolled via the Marketplace. If you are currently enrolled in Ambetter Health, please contact Member Services with any questions related to your health insurance coverage.

## Coverage Effective Dates for Special Enrollment Periods

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

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

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

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

the plan selection is made after the date of the triggering event, coverage is effective on the first day of the following month.

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

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

# PREMIUMS

## Premium Payment

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

## Grace Period

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

## Third Party Payment of Premiums or Cost Sharing

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

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

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

## Misstatement of Age

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

## Change 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 section on Special Enrollment Periods provisions for more information.

## Misstatement of Tobacco or Nicotine Use

The answer to the tobacco or nicotine question on the enrollment application is material to our correct underwriting. If a *member's* use of tobacco or nicotine has been misstated on the *member*'s

application for coverage under this *contract*, we have the right to rescind the *contract* back to the original *effective date.* For additional information see the *Rescission*s provision of this *contract.*

# COST SHARING FEATURES

## Cost Sharing Features

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

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

## Coinsurance Amount

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

## Deductible

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

## 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* are due as shown in your *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.

## Maximum Out-of-Pocket

You must pay any applicable *copayments*, *coinsurance or deductible 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% of the cost for *covered services*. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket amount*. For the family *maximum out-of-pocket amount*, once a *member* has met the individual *maximum out-of-pocket amount*, the remainder of the family *maximum out-of-pocket amount* can be met with the combination of any one or more *members*' *eligible expenses*.

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

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

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

## Non-Network Liability and Balance Billing

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

## Health Savings Account (HSA)

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

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

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

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

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

# ACCESS TO CARE

## Primary Care Physician

You may select any *network* PCP within a provider group who is accepting new patients, or you may select a *network* provider of which you are a current patient who is within a provider group. If you do not select a *network* PCP for each *member*, one may be assigned. You may obtain a list of *network* PCPs at AmbetterHealth.com or by contacting Member Services.

Your PCP coordinates your medical care, as appropriate, either by providing treatment or by issuing *referral*s to direct you to *network* providers. Except for emergency care, only those services which are provided by or referred by your PCP will be covered. It is your responsibility to consult with your PCP in all matters regarding your medical care. If your PCP performs, suggests, or recommends a course of treatment for you that includes services that are not *covered service*s, the entire cost of any such *non-covered services* will be your responsibility.

If your PCP refers you to a *specialist* provider in the same provider group as your PCP, a written *referral* will not be required. Written *referrals* will be required for care received outside of your PCP group.

In addition to a PCP, female *member*s may also select a participating Obstetrician/Gynecologist (OB/GYN) for gynecological and obstetric conditions, including annual well-woman examinations and maternity care, without first obtaining a *referral* from a PCP or contacting us. Mental health or *substance use disorder* providers do not require a *referral*.

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

## Changing Your Primary Care Physician (PCP)

You may change your *network primary care physician* by submitting a written request or by contacting our office at the number shown on your *member* identification card. The change to your *network primary care physician* of record will be effective no later than 30 calendar days from the date we receive your request.

## Contacting Your Primary Care Physician

To make an appointment with your *PCP*, call his/her office during business hours and set up a date and time. If you need help, call Member Services and we will help you make the appointment. If you need to cancel or change your appointment, call 24 hours in advance. At every appointment, make sure you bring your *member* identification card and 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 1-833-543-3145 (TTY 711). A licensed nurse is always available and ready to answer your health questions. In an emergency, call 911 or head straight to the nearest emergency room.

## Network Availability

The *network* is subject to change. The most current *network* may be found online at our website or by contacting us at the number shown on your *member* identification card. A *network* may not be

available in all areas. If you move to an area where we are not offering access to a *network*, please contact Member Services prior to moving or as soon as possible. You may have the opportunity to disenroll from coverage under this *contract* and enroll in a different health plan with a *network* in that area. **NOTE:** Services received from *non-network providers* are generally not *covered services* under this *contract,* except when *balance billing protections* apply to a *covered service* provided by a *non-network provider*. If you receive *covered services* from *non-network providers* that are not subject to *balance billing* protections, benefits will be calculated in accordance with the terms of this *contract* for *non-network providers*.

## Coverage Under Other Provisions

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

## Non-Emergency Services

If you are traveling outside of the Mississippi *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 Mississippi by searching the relevant state in our provider directory at guide.ambetterhealth.com. Not all states have Ambetter plans. If you receive care at an Ambetter *physician* 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 call us and report your emergency within one business day. You do not need prior approval for emergency care services.

## Continuity of Care

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

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

## New Technology

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

1. New technology
2. New medical procedures

3. New drugs
4. New devices
5. New application of existing technology

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

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

## Preferred Partnership

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

## Hospital Based Providers

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

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

# MAJOR MEDICAL EXPENSE BENEFITS

Ambetter Health Solutions provides coverage for healthcare services for a *member* and/or dependents. Some services require *prior authorization*. *Copayment*, *deductibles*, and *coinsurance amounts* must be paid to your *network* provider at the time you receive services. All *covered services* are subject to conditions, exclusions, limitations, terms, and provisions of this *contract*. *Covered service* must be *medically necessary* and not *Experimental* or *investigational*.

## Acquired Brain Injury Services

Benefits for *eligible expense*s incurred for *medically necessary* treatment of an *acquired brain injury* will be determined on the same basis as treatment for any other physical condition.

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

Treatment for an *acquired brain injury* may be provided at a *hospital*, an acute or post-*acute rehabilitation hospital*, a skilled nursing facility, or an approved facility where covered services are provided. Treatment goals for services may include the maintenance of functioning, or the prevention or slowing of further deterioration. *Custodial care* and long-term nursing care are not covered services under this *contract.*

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

1. Has incurred an *acquired brain injury*;
2. Has been unresponsive to treatment;
3. Is medically stable; and
4. To ensure that appropriate post-acute care treatment is provided, this plan includes coverage for *eligible expense*s 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.

## Acupuncture

*Covered services* and supplies for acupuncture treatment are provided on an outpatient basis when provided by a network provider. See the *Schedule of Benefits* for benefit levels or additional limits.

## Ambulance Services

### Air Ambulance Service Benefits

*Covered services* will include ambulance services for, transportation by fixed wing and rotary wing air ambulance from home, scene of accident, or *emergency condition*, subject to other coverage limitations discussed below:

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

Non-emergency *air ambulance* services require *prior authorization. Prior authorization* is not required for air ambulance services when the *member* is experiencing an *emergency condition.* **NOTE:** You should not be *balance billed* for services from a non-network ambulance provider, beyond your *cost share*, for air ambulance services.

Limitations: Benefits for air ambulance services are limited to:
1. Services requested by police or medical authorities at the site of an emergency.
2. Those situations in which the *member* is in a location that cannot be reached by ground ambulance.

Exclusions: No benefits will be paid for:
1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law;
2. Non-emergency *air ambulance* 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).

**Ambulance Services (Ground and Water)**
*Covered service expenses* will include ambulance services for ground and water transportation, transportation from home, scene of accident, or *emergency condition*:
1. In cases where the *member* is experiencing an *emergency condition*, to the nearest *hospital* that can provide *emergency services* appropriate to treat the *member*'s *emergency condition*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, injuries, congenital birth defects, or complications of premature birth that require that level of care.
3. Transportation between *hospitals* or between a *hospital* and skilled nursing or *rehabilitation facility* when *authorized* by Ambetter.
4. When ordered by an employer, school, fire or public safety official and the *member* is not in a position to refuse; or
5. When a *member* is required by us to move from a non-*network* provider to a *network* provider.

*Prior authorization* is not required for emergency ambulance transportation. Note: non-emergency ambulance transportation requires *prior authorization*. **NOTE:** Unless otherwise required by federal or Mississippi law, if you receive services from non-network ambulance providers, you may be balance billed.

Exclusions:
No benefits will be paid for:

1. Expenses incurred for ambulance services covered by a local government or municipal body, unless required by law;
2. Ambulance services provided for a *member*'s comfort and convenience;
3. Non-emergency transportation.

## Autism Spectrum Disorder Benefits

Coverage is provided for *autism spectrum disorder*s when prescribed by a *physician* or *behavioral health* practitioner and includes the following:

1. Evaluation and assessment services;
2. *Applied behavior analysis* therapy;
3. Behavior training and behavior management;
4. Speech therapy;
5. Occupational therapy;
6. Physical therapy;
7. Psychiatric care such as counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor, or clinical social worker; and
8. Medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

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

## Benefit Limitations

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

## Cancer Drug Expense Benefits

*Covered service expenses* in this benefit include coverage for any other use of a drug for the treatment of cancer if that drug is recognized for the treatment of that specific type of cancer, for which it has been prescribed, in one of the standard reference compendia or medical literature.

Standard reference compendia means:

1. The "United States Pharmacopoeia Drug Information"; or
2. The "American Hospital Formulary Service Drug Information."

Medical literature means: two (2) articles from major peer-reviewed professional medical journals that have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed unless two (2) articles from major peer-reviewed professional medical journals have concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed. Peer-reviewed medical literature shall not include publications or supplements that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

Coverage will not include any *experimental* drug used for the treatment of cancer if a drug has not been approved by the FDA or the use of a drug that is contraindicated by the FDA.

## Care Management Programs

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

1. Better understand and manage your health conditions.
2. Coordinate services.
3. Locate community resources.

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

## Clinical Trials for Cancer and Other Life-Threatening Illnesses

*Coverage* will include routine care costs incurred for*:*

1. Drugs and devices that have been approved for sale by the 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 that are 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 *member* in the trial

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

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

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

*Covered service expenses* include the costs of:

1. Prevention, diagnosis, treatment, and palliative care of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted;
2. Medical care for an approved clinical trial related to cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, that would otherwise be covered under a health care insurance plan if the medical care were not in connection with an approved clinical trial;
3. Items or services necessary to provide an *investigational* item or service;
4. The diagnosis or treatment of complications;

5. A drug or device approved by the FDA without regard to whether the FDA approved the drug or device for use in treating a patient's particular condition, but only to the extent that the drug or device is not paid for by the manufacturer, distributor, or provider of the drug or device;
6. Services necessary to administer a drug or device under evaluation in the clinical trial; and
7. Transportation for the patient that is primarily for and essential to the medical care.

*Covered service expenses* do not include:

1. A drug or device that is associated with the clinical trial that has not been approved by the FDA;
2. Housing, companion expenses, or other nonclinical expenses associated with the clinical trial;
3. An item or service provided solely to satisfy data collection and analysis and not used in the clinical management of the patient;
4. An item or service excluded from coverage under the patient's health care insurance plan; and
5. An item or service paid for or customarily paid for through grants or other funding.

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

## Dental Anesthesia Coverage

*Covered service expenses w*hen rendered in a *hospital* setting and for associated *hospital* charges when the mental or physical condition of the insured person requires dental treatment to be rendered in a *hospital* setting.

## Diabetic Care Expense Benefits

Benefits are available for *medically necessary* services and supplies used in the treatment of persons with gestational, type I or type II diabetes. *Covered service expenses* include, but are not limited to:

1. Examinations, including podiatric examinations;
2. Routine foot care such as trimming of nails and corns;
3. Laboratory and radiological diagnostic testing;
4. Self-management equipment, and supplies such as urine and/or ketone strips,
5. blood glucose monitor supplies, glucose strips for the device, and syringes or needles;
6. Orthotics and diabetic shoes;
7. Urinary protein/microalbumin and lipid profiles;
8. Educational health and nutritional counseling for self-management,
9. Eye examinations, and prescription medication; and retinopathy examination screenings, as medically necessary.

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

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

Refer to your *Schedule of Benefits* for any limitations associated with medical and surgical expense benefits.

## 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. You may receive hemodialysis in a dialysis facility or peritoneal dialysis in your home from a *network provider*.
Covered expenses include:

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

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

## Disposable Medical Supplies

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

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

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

1. The equipment, supply or appliance is a *covered service*;
2. The continued use of the item is *medically necessary*; and
3. There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

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

1. The equipment, supply or appliance is worn out or no longer functions;
2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by a *network 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.

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

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

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

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

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

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

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

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

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

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

*Covered services* may include, but are not limited to:

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

**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. *Prior authorization* may be required for *medically necessary* corrective foot wear
Covered *orthotic devices* may include, but are not limited to, the following:

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

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

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

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

## 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 treat you within the emergency room may not be contracted with Ambetter. If that is the case, they may not *balance bill* you for the difference between our *allowed amount* and the provider's *billed charge*.

## Essential Health Benefits

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

## Family Planning and Contraception

Family planning and contraception benefits are covered under preventive care, without *cost sharing*, when provided by a *network* provider and the care is legal under *applicable law*. These benefits 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 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.

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

## Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

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

1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.

2. *Rehabilitation services* or confinement in a *rehabilitation facility* or *Extended care facility* must be determined *medically necessary*;
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
    a. Daily room and board and nursing services;
    b. Diagnostic testing;
    c. Drugs and medicines that are prescribed by a provider, filled by a licensed pharmacist, and approved by the U.S. Food and Drug Administration;
    d. Cardiac and pulmonary *rehabilitation;*
4. *Covered service expenses* for non-provider *facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners;*
5. Outpatient physical therapy, occupational therapy, and speech therapy.

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

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

## Home Health Care Service Expense Benefits

*Covered service expenses* for *home health care* are limited to the following charges 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,* only if provided in conjunction with skilled registered nurse or licensed practical nursing services;
2. Skilled services of a registered nurse or licensed practical nurse rendered on an outpatient basis;
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.* Please refer to your *Schedule of Benefits* for any limits associated with this benefit;
4. Hemodialysis, and for the processing and administration of blood or blood components;
5. *Necessary medical supplies*;
6. Rental of *medically necessary durable medical equipment* at the discretion of the plan. At our option, we may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider we authorize before the purchase*;*
7. Sleep studies are covered when determined to be *medically necessary*; *prior authorization* may be required;
8. Intravenous medication and pain medication are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay. We may authorize the purchase of the equipment from a *network* provider in lieu of its rental if the rental price is projected to exceed the equipment purchase price.

Limitations:

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

*Schedule of Benefits* Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational 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. *Respite care* is covered on an *inpatient* or home basis to allow temporary relief to family members from the duties of caring for a *member* who is undergoing *hospice* care. Respite days that are applied toward the *member*'s *deductible amount* are considered benefits provided and shall apply against any maximum benefit limit for these services. See your *Schedule of Benefits* for coverage limits.

*Covered services* include:

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

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

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

Benefits for *hospice inpatient* or home care are available to a *terminally ill* covered person. Benefits for *hospice inpatient*, home and outpatient care is subject to *prior authorization* as outlined in this *contract.*

## Hospital Benefits

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

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

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

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

1. Complex wound care:
    a. Daily *physician* monitoring of wound.
    b. Wound requiring frequent complicated dressing changes and possible repeated debridement of necrotic tissue.
    c. Large wound with possible delayed closure, draining, and/or tunneling or high output fistulas.
    d. Lower extremity wound with severe ischemia.
    e. Skin flaps and grafts requiring frequent monitoring.
2. Infectious disease:
    a. Parenteral anti-infective agent(s) with adjustments in dose.
    b. Intensive sepsis management.
    c. Common conditions include osteomyelitis, cellulitis, bacteremia, endocarditis, peritonitis, meningitis/encephalitis, abscess and wound infections.
3. Medical complexity:
    a. Primary condition and at least two other actively treated co-morbid conditions that require monitoring and treatment.
    b. Common conditions include metabolic disorders, stroke, heart failure, renal insufficiency, necrotizing pancreatitis, emphysema (COPD), peripheral vascular disease, and malignant/end-stage disease.
4. *Rehabilitation*:
    a. Care needs cannot be met in a *rehabilitation* or skilled nursing facility.
    b. Patient has a comorbidity requiring acute care.
    c. Patient is able to participate in a goal-oriented *rehabilitation* plan of care.
    d. Common conditions include CNS conditions with functional limitations, debilitation, amputation, cardiac disease, orthopedic *surgery.*
5. Mechanical ventilator support:
    a. Failed weaning attempts at an acute care facility
    b. Patient has received mechanical ventilation for 21 consecutive days for 6 hours or more/ per day.
    c. Ventilator management required at least every 4 hours as well as appropriate diagnostic services and assessments.
    d. Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions.
    e. Patient is hemodynamically stable and not dependent on vasopressors.
    f. Respiratory status is stable with maximum PEEP requirement 10 cm H2O, and FiO2 60% or less with O2 saturation at least 90%.
    g. Common conditions include complications of acute lung *injury*, disorders of the central nervous and neuromuscular systems, and cardiovascular, respiratory, and pleural/chest wall disorders.
    h. Patient continues to meet the criteria above and does not meet the criteria to be transitioned to alternate level of care.

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

## Maternity Care
An *inpatient* stay is covered for mother and newborn for a minimum of 48 hours following a vaginal delivery and 96 hours following a delivery by cesarean section. We do not require that a provider or other healthcare provider obtain *prior authorization* for the delivery.

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

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

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

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

**NOTE:** This provision does not amend the *contract* to restrict any terms, limits, or conditions that may otherwise apply to *surrogates* and children born from *surrogates*. Please reference General Non-*Covered service*s 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 *surrogate arrangement.* For more information on excluded services, please see the General Non-Covered Services and Exclusions section of this *contract. 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 Magnolia Health Plan at the Member Services, 1020 Highland Colony Parkway Suite 502, Ridgeland, MS 39157 In the event that a *member* fails to comply with this provision, we reserve our right to enforce this provision on the basis of fraud, misrepresentation, or false information, up to and including recoupment of all benefits that we paid on behalf of the *surrogate* during the time that the *surrogate* was insured under our *contract*, plus interest, attorneys' fees, costs and all other remedies available to us.

## Medical and Surgical Expense Benefits
*Covered services provided* under this provision are subject to all other terms and conditions of the *contract*, including *deductible amount* and *cost sharing* provisions. *Covered services* include, but are not limited to, *prior authorizations* and charges:

1. For *surgery* in a provider's office, an *inpatient* facility, an *outpatient* facility or a *surgical facility,* including services and supplies.
2. For *pre-surgical* and *post-surgical procedures* and testing, including but not limited to, diagnostic services using radiologic, ultrasonographic or laboratory services:
    a. Laboratory tests or radiological examinations done on an outpatient basis in a *hospital* or other facility accepted by the *hospital* before *hospital* confinement or outpatient *surgery* or procedures. The tests must be for the same bodily *illness* or *injury* causing the *member* to be *hospitalized* or to have the outpatient *surgery* or procedure.
    b. Bone density studies.
    c. Clinical laboratory tests.
    d. Gastrointestinal laboratory procedures.
    e. Pulmonary function tests.
    f. Genetic testing.
    g. For *medically necessary* genetic or molecular cancer testing, including but not limited to, tumor mutation testing, next generation sequencing, hereditary germline mutation testing, pharmacogenomics testing, whole exome, genome sequencing and biomarker testing.
3. For medical services in an office or facility that is provided by a licensed *medical practitioner* or *specialist* provider, including consultations and *surgery* related services.
4. For elective sterilization procedures (i.e., vasectomies). **NOTE**: No cost-share applies, except on HSA-compatible plans.
5. For chemotherapy (including oral chemotherapy), inhalation therapy, infusion therapy, and radiation therapy or treatment in a *hospital* or office setting.
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 *contract*. 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 *contract*
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* as a result of a partial or total mastectomy for breast cancer. 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 *contract*. See the Clinical Trial Coverage provision of this *contract*.
14. For the following types of *medically necessary* implants and tissue grafts:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.
    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 *contract*.
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 Habilitation, Rehabilitation and Extended Care Facility Expense Benefits and Extended Care Expense Benefits provisions of this *contract*.
20. 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.
21. For *medically necessary* footcare treatment that may require *surgery*; *prior authorization* may be required.
22. 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.
23. For *medically necessary* biofeedback services.

24. For therapeutic abortion performed to save the life or health of the *member*.
25. 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.
26. For *medically necessary chiropractic care* or manipulative therapy treatment on an outpatient basis only.
27. 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.
28. For *medically necessary* allergy testing and treatment including allergy injections and serum.
29. *Medically necessary* nutritional counseling. *Prior authorization* may be required.

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

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

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

## Medical Dental Services

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

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

Coverage is also provided for:

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

h. *Reconstructive surgery* to correct significant deformities caused by congenital or developmental abnormalities, *illness*, *injury,* or an earlier treatment in order to create a more normal appearance.

2. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* or office charges for dental care, rendered by a dentist, regardless of whether the services are provided in a participating *hospital*, surgical center, or office, provided to the following *member*s:
   a. A *member* under the age of 8
   b. a person who is severely disabled; or
   c. a person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.
3. For dental service expenses when a *member* suffers an *injury*, that results in:
   a. Damage to his or her natural teeth.
   b. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
4. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, or malocclusions.

## Medical Foods

We cover medical foods and formulas for:

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

Coverage also includes other heritable diseases, regardless of the formula delivery method. Coverage for inherited diseases of amino acids and organic acids shall, in addition to the enteral formula, include food products modified to be low protein. Such coverage shall be provided when the prescribing *physician* has issued a written order stating that the enteral formula or food product is *medically necessary*.

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

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

### Low-Protein Food Products for Treating Inherited Metabolic Diseases

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

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

1. Phenylketonuria (PKU)

2. Maple Syrup Urine Disease (MSUD)
3. Methylmalonic Acidemia (MMA)
4. Isovaleric Acidemia (IVA)
5. Propionic Acidemia
6. Glutaric Acidemia
7. Urea Cycle Defects
8. Tyrosinemia

## Medical 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.

Vision services under the medical portion of your health plan do not include:

1. *Referral*s to a *specialist* for evaluation and diagnosis of refractive error, including presbyopia, for *member*s 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.

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

## Mental Health and Substance Use Disorder Benefits

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

Services will be provided on an *inpatient* and *outpatient* basis for the treatment of mental health and *substance use disorder* diagnoses. If you need mental health and/or *substance use disorder* treatment, you may choose any provider participating in our mental health *network* in order to initiate treatment. *Deductible amounts*, *copayment* or *coinsurance amounts* and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits. You can search for *network behavioral health* providers by using our “Find a Doctor” tool at AmbetterHealth.com or by calling Member Services.

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

When making coverage determinations, our mental health and *substance use disorder* 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 and *substance use disorder* staff utilizes Change Healthcare 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 and/or *substance use disorder* services are as follows:

**Inpatient**

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

**Outpatient**

1. Partial Hospitalization Program (PHP).
2. Intense *Outpatient* Program (IOP).
3. Mental Health Day treatment.
4. Outpatient detoxification programs.
5. Evaluation and assessment for mental health and *substance use disorder*.
6. Individual and group therapy for mental health and *substance use disorder*.
7. Medication Assisted Treatment – combines behavioral therapy and medications to treat *substance use disorders*.
8. Medication management services.
9. Psychological and Neuropsychological testing and assessment.
10. *Applied Behavior Analysis*.
11. *Telehealth* (individual/family therapy; medication monitoring; assessment and evaluation);
12. Electroconvulsive Therapy (ECT).
13. Biofeedback.
14. *Transcranial magnetic stimulation* (*TMS*).

Expenses for these services are covered if *medically necessary*, and may be subject to *prior authorization*. However, we will not require *prior authorization* for emergent *inpatient* withdrawal management services or emergent *inpatient* treatment services. Please see your *Schedule of Benefits* for more information regarding services that require *prior authorization*.

In addition, Integrated *Care Management* is available for all of your healthcare needs, including mental health and *substance use disorder*. Please call 1-833-543-3145 (TTY 711) to be referred to a care manager for an assessment.

## Newborn Charges

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

## Newborns' and Mothers' Health Protection Act Statement of Rights

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

## Outpatient Medical Supplies Expense Benefits

*Covered expenses* 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. If more than one *prosthetic device* can meet a *covered person's* functional needs, only the charge for the most cost-effective *prosthetic device* will be considered a *covered expense*.
2. For *medically necessary* foot orthotics, *prior authorization* may be required.
3. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
4. For the rental of one continuous passive motion (CPM) machine per covered person following a covered joint surgery.
5. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract *surgery*.
6. Services related to diagnosis, treatment, and appropriate management of osteoporosis when such services are provided by a person licensed to practice medicine and *surgery* in the state, if the *member* has a condition or medical history for which bone mass measurement is medically indicated.
7. Testing of pregnant women and other *members* for lead poisoning.
8. For all United States Food and Drug Administration (FDA)-approved contraception methods without *cost sharing* as required under the Affordable Care Act
9. Infusion Therapy

## Pediatric Vision Expense Benefits – Children Under the Age of 19

Coverage for vision services is provided for children, under the age of 19, from a *network* provider through the end of the plan year in which they turn 19 years of age.

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 aids as *medically necessary*

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

Services not covered:
1. Deluxe frame/frame upgrade
2. Visual therapy
3. Two pair of glasses as a substitute for bifocals
4. LASIK *surgery*
5. Replacement eyewear

## Prescription Drug Expense Benefits

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

*Covered service expenses* in this benefit subsection are limited to charges from a licensed pharmacy for:
1. A *prescription drug*;
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a provider.
3. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one (1) standard reference compendium; or
    b. Recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
4. Self-administered human growth hormones to treat children with short stature who have an absolute deficiency in natural growth hormone. Benefits are also available to treat children with short stature who have chronic renal insufficiency and who do not have a functioning renal transplant.
5. Prescribed, oral anti-cancer medication.

Such *covered service expenses* shall include those for prescribed, orally administered anti-cancer medications. The *covered service expenses* shall be no less favorable than for intravenously administered or injected cancer medications that are covered as medical benefits under this *contract*. The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her *physician.*

### How to Fill a Prescription

Your *prescription order* can be filled at a *network* retail pharmacy or through our mail-order pharmacy.

If you decide to have your *prescription order* filled at a *network* pharmacy, you can use the Provider Directory to find a pharmacy near you. You can access the Provider Directory at AmbetterHealth.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 AmbetterHealth.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.

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

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

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

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the formulary. For the most current Ambetter Formulary or *Prescription Drug* List or for more information about our pharmacy program, visit AmbetterHealth.com (under "For Member", "Drug Coverage") or call Member Services.

**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" for additional details.

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

**Lock-in Program**
To help decrease overutilization and abuse, certain *members* identified through our lock-in program,

may be locked into a specific *network* pharmacy of their choosing for the duration of their participation in the lock-in program. *Members* locked into a specific pharmacy will be able to obtain their medication(s) only at specified location. These medications still may require a *prior authorization* be submitted by your provider. Ambetter pharmacy, together with Medical Management will review *member* profiles and using specific criteria, will recommend *members* for participation in lock-in program. *Members* identified for participation in lock-in program and associated providers will be notified of *member* participation in the program via mail. Such communication will include information on duration of participation, pharmacy to which *member* is locked-in, and any *appeals* rights.

**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.

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

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

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

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

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

an expedited exception request, we will provide coverage of the non-formulary drug for the duration of the exigency.

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

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

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

Notice and *proof of loss*:
In order to obtain payment for *covered service expenses* incurred at a *pharmacy* for *prescription orders,* a notice of claim and *proof of loss* must be submitted directly to us.

*Non-covered services* and exclusions:
No benefits will be paid under this benefit provision for services provided or expenses incurred:

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance unless such treatment is listed on the formulary.
2. For weight loss *prescription drugs* unless otherwise listed on the formulary.
3. For immunization agents, blood, or blood plasma, except when used for preventive care and listed on the formulary.
4. For medication that is to be taken by the *member,* in whole or in part, at the place where it is dispensed.
5. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
6. For a refill dispensed more than 12 months from the date of a *physician's* order.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over the counter form or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are listed on the formulary.
9. For drugs labeled "Caution - limited by federal law to *investigational* use" or for *investigational* or *experimental* drugs.
10. For any drug that we identify as therapeutic duplication through the drug *utilization review* program.
11. For more than a 30-day supply when dispensed in any one prescription or refill, or for maintenance drugs up to a 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply *network*. Specialty drugs, and other select drug categories, are limited to 30-day supply when dispensed by retail or mail order. **NOTE:** that only the 90-day supply may be subject to the discounted *cost sharing*. Mail orders less than 90 days are subject to the standard *cost sharing* amount.
12. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.

13. Foreign *prescription medications*, except those associated with an *emergency 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 preventative treatment is related to *member's* vacation during out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
15. For medications used for cosmetic purposes.
16. For infertility drugs unless otherwise listed on the formulary.
17. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
18. For drugs or dosage amounts determined by Ambetter's Pharmacy and Therapeutics committee to be ineffective, unproven or unsafe for the indication for which they have been prescribed, regardless of whether such drugs or dosage amounts have been approved by any governmental regulatory body for that use
19. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
20. For any drug dispensed from a non-lock-in pharmacy while *member* is in a lock-in program.
21. For any drug related to *surrogate pregnancy*.
22. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
23. 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.
24. Medication refills where a *member* has more than 15 days' supply of medication on hand.
25. Compound drugs, unless there is at least one ingredient that is an FDA approved drug.

## Preventive Care Expense Benefits

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

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
4. With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA, to the extent the care is not illegal under *applicable law.*

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

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

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

As new preventive care recommendations and guidelines are issued (by the USPSTF, CDC or HRSA), those services will become covered preventive care benefits. According to the ACA, coverage of new recommendations and guidelines become effective upon a plan's start or anniversary date that is one year after the date the recommendation or guideline is issued.
In addition to providing coverage in accordance with the ACA, we also provide preventive care benefits in accordance with applicable state law.

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

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 AmbetterHealth.com or by contacting Member Services.

## Prostate Specific Antigen Testing

*Covered services* include an annual digital rectal examination and prostate specific antigen test performed to determine the level of prostate specific antigen in the blood for a *member* who is at risk and at least fifty years of age; (if high-risk of prostate cancer, eligibility starts between 40 – 49 years of age).

## 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 (CAT scan), Positron Emission Tomography (PET scan), and ultrasound imaging). *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.

## Respite Care Expense Benefits

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

## Second Medical Opinion

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

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

If requested, the second opinion consultation is to be provided by a *physician* of the *member's* choice. The *member* may select a *network* provider listed in the provider directory. If a *member* chooses a *network* provider, he or she will only be responsible for the applicable *cost sharing* for the consultation. Any lab tests and/or diagnostic and therapeutic services are subject to additional *cost sharing*. If a second medical opinion is obtained by a *non-network provider*, *prior authorization* must be obtained before services are considered an *eligible expense*. If *prior authorization* is not obtained for a second medical opinion from a *non-network provider*, you will be responsible for the related expenses. If you see a *non-network provider*, you may be *balance billed* for services received.

## Sleep Studies

Sleeps 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.

## Temporomandibular Joint Disorder and Craniomandibular Disorder Expense Benefits

*Covered service expenses* expanded to include the charges incurred for diagnostic services and *surgery* for temporomandibular joint disorder and craniomandibular disorder. These expenses shall be the same as that for treatment to any other joint in the body. Coverage shall apply if the treatment is administered or prescribed by a *primary care physician* or dentist.

## 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 *contract*. *Prior authorization* must be obtained through the *"Center of Excellence" before* an evaluation for a transplant. We may require additional information such as testing and/or treatment before determining medical necessity for the transplant benefit. *Authorization* must be obtained prior to performing any related services to the transplant *surgery*. Transplant services must meet medical criteria as set by Medical Management Policy.

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

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

If we determine that a *member* and donor are appropriate candidates for a *medically necessary* transplant, or live donation, *covered service expense* benefits will be provided for:

1. Pre-transplant evaluation.

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

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

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

1. We will pay for the following services when the *member* is required to travel more than 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 *member,* any live donor, and the companion(s) to accompany the *member* to and from the *Center of Excellence,* in the United States.
    b. When *member*, donor and /or companion(s) is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
    c. Maximum reimbursement for mileage is limited to the total miles traveled by the transplant recipient and by the donor and their respective companion(s), to and from their homes to the transplant facility, plus miles traveled:
        i. Between the transplant facility and local lodging; and
        ii. Between a transit hub (e.g., airport, train station, bus station) and either the transplant facility or local lodging.
    d. Lodging at or near the *Center of Excellence* for any live donor and or companion(s) accompanying the *member* while the *member* is confined in the *Center of Excellence* in the United States. We will reimburse *members* for the proof of the 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 the service in order to be reimbursed.

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

Non-Covered services and exclusions:

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

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *medically necessary* transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the *Center of Excellence*.
4. To keep a donor alive for the transplant operation, except when *authorized* through the *Center of Excellence*.
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
6. Related to transplants *unauthorized* 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 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 un*authorized* facility or not obtained through the *Center of Excellence*.
9. For any transplant services and/or travel related expenses for *member* and donor, when preformed outside of the United States.
10. The following ancillary items listed below, will not be subject to *member* reimbursement under this *contract*:
    a. Alcohol/*tobacco*
    b. Car, trailer or truck 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, (unless preapproved by Case Management)
    e. Storage rental units.
    f. Temporary housing incurring rent/mortgage payments.
    g. Loss of wages due to time off from work required for transplant for recipient, donor, or companion(s)
    h. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
    i. Moving violation tickets or parking tickets
    j. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
    k. For any services related to pet care, boarding, lodging, food, and/or travel expenses.
    l. Expenses for persons other than the transplant recipient, donor or their respective companion(s).
    m. Expenses for lodging when the transplant recipient, donor, or their respective companion(s) are staying with a relative, friend or otherwise have free lodging.
    n. Any expense not supported by a receipt
    o. Upgrades to first class travel (air, bus, and train)
    p. Personal care items (e.g., shampoo, deodorant, clothes)
    q. 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.
    r. Souvenirs (e.g., t-shirts, sweatshirts, toys)
    s. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type.
    t. All other items not described in the *contract* as *eligible expenses.*
    u. Any fuel costs/charging station fees for any vehicle (but **NOTE:** that mileage is reimbursable).
    v. Any tips, concierge, club level floors, and gratuities.
    w. Salon, barber, and spa services.
    x. Insurance premiums
    y. *Cost share* amounts owed to the transplant surgeon or facility or other provider.

## Urgent Care Service Benefits

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 contracted *urgent care center*s 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 1-833-544-3145 (TTY 711). The 24/7 Nurse Advice Line is available 24 hours a day, 7 days a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

# WELLNESS PROGRAMS AND OTHER OFFERINGS

In connection with this contract, we may offer wellness programs and other services to *members* that serve to remove barriers to accessing health services and improve overall health outcomes. These programs and services are available when your coverage begins and continue as long as your coverage remains active. Participation in these programs and services is optional and available at no additional cost to *members*. The programs and services are available to you as part of this contract but are not insurance. We may make changes to the terms and conditions of the programs and services or discontinue them at any time. Program tools and service may vary within your market. To inquire about these programs and other offerings, and to learn about what programs are available in your area, please visit our website at AmbetterHealth.com or by contacting Member Services.

The Ambetter Health preventive care and wellness program includes offerings for health check-ups, screenings for common conditions and vaccinations. Rewards may be available through the "My Health Pays" program for completing specific activities that promote healthy behaviors and address *social determinants of health*. *Members* may receive communications and outreach about this program.

We also offer general wellness, health improvement and care management programs that may include a reward or incentive that you may earn for completing different wellness-related activities.

If you have a medical condition that may prohibit you from participating in a wellness program, 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 can access other services in connection with this contract, such as the "Ambetter Health Perks" program, which offers discounts on a wide range of activities, services, goods, financial tools, memberships, out-of-pocket prescription expenses, over-the-counter (OTC) health products, and health- and wellness-related services addressing *social determinants of health* and healthy lifestyle. *Members* are responsible for paying for the discounted goods or services and we do not endorse any vendor, goods or services associated with the program. Members may also have access to a zero-interest line of credit through the Ambetter Health Perks program for paying their deductibles, copayments, and coinsurance on *covered services*, with several repayment options to fit their needs. The Ambetter Health Perks program is offered to all *members*. We are not involved in administering programs; you will communicate directly with any vendors if you choose to participate.

# PRIOR AUTHORIZATION

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

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

## Prior Authorization Required

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

For services, items, or supplies that require *prior authorization*, as shown in your *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 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* (medical and *behavioral health*) requests must be received by telephone, fax or provider portal as follows:

1. At least five days prior to an elective admission as an *inpatient* in a *hospital*, extended care, or *rehabilitation facility*, *hospice* facility, or *residential treatment facility*.
2. At least 30 days prior to the initial evaluation for organ transplant services.
3. At least 30 days prior to receiving clinical trial services.
4. Within 24 hours of any *inpatient* admission, including emergent *inpatient* admissions.
5. At least five days prior to the start of *home health care* except those *members* needing *home health care* after *hospital* discharge.

After *prior authorization* has been received , we will notify you and your provider if the request has been approved as follows:

1. For urgent concurrent reviews within 1 calendar day of receipt of the request.
2. For urgent pre-service reviews, within 48 hours from the date of receipt of the request.
3. For non-urgent pre-service reviews within 7 calendar days from date of receipt of the request.
4. For post-service or retrospective reviews, within 30 calendar days from date of receipt of the request.

In situations where additional information is needed to make a decision, these timeframes may be extended in accordance with applicable law.

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. For a list of participating *medical practitioners* who specialize in obstetrics or gynecology, contact Member Services

## How to Obtain Prior Authorization

To obtain *prior authorization* or to confirm that a network provider has obtained *prior authorization*, contact Member Services 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 the *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 *contract.*

## Prior Authorization Denials

Refer to the *Appeal*, *Complaint* and *Grievance* Procedures section of this *contract* 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. 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 *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.

# GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

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

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*.
2. For any portion of the charges that are in excess of the *eligible expense.*
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery,* and bariatric *surgery,* except as specifically covered in the *Major Medical Expense Benefits* section of this contract.
4. For weight loss programs, gym memberships, exercise equipment, or meal preparation programs.
5. For cosmetic breast reduction or augmentation, except for the *medically necessary* treatment of gender dysphoria.
6. For the reversal of sterilization and vasectomies.
7. For abortion, except in the case of rape, or when the life of the mother would be endangered if the fetus were carried to term, or as required by *applicable law*.
8. For expenses for television, telephone, or expenses for other persons.
9. For career counseling, marriage, divorce, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
10. For telephone consultations, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
11. For stand-by availability of a *medical practitioner* when no treatment is rendered.
12. For *dental service expenses,* including braces for any medical or dental condition, *surgery,* and treatment for oral *surgery*, except as expressly provided for under Medical and Surgical Expense Benefits.
13. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Medical and Surgical Expense Benefits provision.
14. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect.
15. For diagnosis or treatment of learning disabilities*.*

16. For diagnosis or treatment of nicotine addiction.
17. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
18. For eye refractive *surgery when* the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
19. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
20. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
21. For eyeglasses, contact lenses, hearing aids, Cochlear Implants, Bone Anchored Hearing Aids, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
22. Hearing aids, except as specifically provided under the *contract.*
23. 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.
24. For treatment received outside the United States, except for a medical emergency while traveling for up to a maximum of (90) consecutive days.
25. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is *appealed* to the proper governmental agency and the denial is upheld by that agency.
26. For fetal reduction *surgery*.
27. Except as specifically identified as a *covered service expense* under the *contract*, services, or expenses for alternative treatments, including acupressure, 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.
28. 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).
29. 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.
30. As a result of any *injury* sustained while at a *residential treatment facility.*
31. 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.
32. For the following miscellaneous items (except where required by federal or state law): in-vitro fertilization, artificial insemination, biofeedback; care or complications resulting from non-

*covered services*; chelating agents; domiciliary care; food and food supplements except for what is indicated in the Medical Foods section; health club memberships, unless otherwise covered; home test kits; 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*; sclerotherapy for varicose veins; treatment of spider veins; transportation expenses, unless specifically described in this *contract*;

33. *Surgical procedure* relating to fertility or infertility.
34. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
35. Mental health services are excluded:
    a. For 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 *contract*.
    d. Testing of ability, aptitude, intelligence, or interest; and
    e. Evaluation for the purpose of maintaining employment. Benefits will be allowed for services that would otherwise be covered under this *contract*.
36. Services which are custodial or residential in nature.
37. Habilitative services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.
38. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status. To facilitate appropriate benefit use and prevent opioid overutilization, *member's* participation in lock-in status will be determined by review of pharmacy claims.
39. *Surrogacy Arrangement*. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a *member*, and any child born as a result of a *surrogacy arrangement*. This exclusion applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
    a. Prenatal care.
    b. Intrapartum care (or care provided during delivery and childbirth).
    c. Postpartum care (or care for the *surrogate* following childbirth).
    d. Mental health services related to the *surrogacy arrangement*.
    e. Expenses relating to donor semen, including collection and preparation for implantation.
    f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*.
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*.
    h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement*.
    i. Any complications of the child or *surrogate* resulting from the *pregnancy*.
    j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*.
    k. Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except where the child is the adoptive child of insureds possessing an active *contract* with us and/ or the child possesses an active *contract* with us at the time of birth; or
40. For any medicinal and recreational use of cannabis or marijuana.
41. For all health care services obtained at an Urgent Care Facility that is a *non-network provider*.
42. For expenses, services, and treatments from acupuncture *specialists* to stimulate the central nervous system.

43. Immunizations that are not *medically necessary* or medically indicated. This includes those used for travel and occupational.
44. For expenses, services, and treatments from a massage therapist to touch and manipulate the muscles and other soft tissues of the body.
45. For expenses, services, and treatments from a Naprapathic *specialists* for conditions caused by contracted, injured, spasmed, bruised, and/or otherwise affected myofascial or connective tissue.
46. For expenses, services, and treatments from a Naturopathic *specialists* for treatment of prevention, self-healing and use of natural therapies.
47. For expenses, services, and treatments of a private duty registered nurse rendered on an outpatient, *inpatient*, or home location.
48. For expenses for services related to dry needling.
49. Vehicle installations or modifications which may include, adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.
50. For immunization agents otherwise not required by the Affordable Care Act
51. For any drug related to *surrogate pregnancy*
52. Assertive Community Treatment (ACT)

# TERMINATION

## Termination of Contract

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date we receive a request from you to terminate this *contract,* 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. For a covered *eligible child* reaching the limiting age of 26, coverage under this *contract*, for a dependent child, will terminate at 11:59 p.m. on the last day of the year in which the *eligible child* turns 26.
4. The date we decline to renew this *contract,* as stated in the Discontinuance provision.
5. The date of your death if this *contract* is an individual plan.

## Refund Upon Cancellation

We will refund any premium paid and not earned due to *contract* termination. You may cancel the *contract* at any time by providing written notice to the entity with which you enrolled. Such cancellation shall become effective upon receipt, or on such later date specified in the notice. If you cancel, we shall promptly return any unearned portion of the premium paid, but in any event shall return the unearned portion of the premium within 20 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.

## Discontinuance

90-Day Notice: If we discontinue offering all *contracts* issued on this form, with the same type and level of benefits, for all residents of the state of Mississippi, 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 the state of Mississippi at the time of discontinuance of this *contract*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180-Day Notice: If we discontinue offering and refuse to renew all individual *contracts* in the individual market in the state of Mississippi, 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 *contracts* in the individual market in the state of Mississippi.

## Notification Requirements

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

## Continuation of Coverage

We will issue the continuation of coverage:

1. No less than 30 calendar days prior to a *member's* 26th birthday; or
2. Within 30 calendar days after the date we receive timely notice of your legal divorce or *dependent member's* marriage. Your former *dependent member* must pay the required premium within 31 calendar days following notice from us or the new *contract* will be void from its beginning.

# SUBROGATION AND RIGHT OF REIMBURSEMENT

If a *member's illness* or *injury* is caused by the acts or omissions of a *third party*, we will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*.

However, if this plan pays benefits on a *member*'s behalf for expenses incurred due to *third party injuries*, we will pay regular *contract* benefits for the *member*'s *loss*. We will have the right to be reimbursed to the extent of benefits we provided or paid for the *illness* or *injury* if the *member* subsequently receives any payment from any *third party*. The *member* (or the guardian, legal representatives, estate, or heirs of the *member*) shall promptly reimburse us from the settlement, judgment, or any payment that *member* receives.

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

1. To fully cooperate with us in order to obtain information about the *loss* and its cause.
2. To immediately inform us in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.
3. To include the amount of benefits paid by us on behalf of a *member* in any claim made against any *third party*.
4. That we:
    a. Will have a lien on all money received by a *member* in connection with the *loss* equal to the benefit amount we have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect our rights.
    d. May seek money in your name, from any person who causes you *injury* and from your own insurance. We can seek money only up to the amount we paid for your care. May assert that subrogation right independently of the *member*.
5. To take no action that prejudices our reimbursement and subrogation rights.
6. To sign, date, and deliver to us any documents we request that protect our reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a *third party* without providing us with written notice no less than 30 calendar days prior to the settlement.
8. To reimburse us from any money received from any *third party* to the extent of benefits we paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses.
9. That we may delay the processing of future claims and / or enforce our right of recovery by offsetting future benefits.

Furthermore, as a condition of our payment, we may require the *member* or the *member's* guardian (if the *member* is a minor or legally incompetent) to execute a written reimbursement agreement. However, the terms of this provision remain in effect regardless of whether or not an agreement is actually signed.

We will not pay attorney fees or costs associated with the *member's* claim or lawsuit unless we previously agreed in writing to do so.

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

# 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 one year late will not be accepted, unless you or your covered *dependent member* had no legal capacity to submit such proof during that year.

## How to Submit a Claim
Providers will typically submit claims on your behalf, but sometimes you may need to submit claims yourself for *covered services*. This usually happens if, your provider is not contracted with us.

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 the *member* reimbursement claim form posted at AmbetterHealth.com under "For Members – Forms and Materials". Send all the documentation to us at the following address:

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

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

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

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

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

claims of all *members*.

## Time for Payment of Claims

All benefits payable under this *contract* for a *loss*, other than *loss* for which this *contract* provides any periodic payment, will be paid within 25 calendar days after receipt of due written proof of such *loss* in the form of a clean claim where claims are submitted electronically, and will be paid within 35 calendar days after receipt of due written proof of such *loss* in the form of clean claim where claims are submitted in paper format. Upon request, the insurer shall provide to the insured or the provider submitting a claim a written list of the information required and the documentation required for the insurer to deem a claim to be clean, and the insurer shall then be bound to such list. Benefits due under the policies and claims are overdue if not paid within 25 calendar days or 35 calendar days, whichever is applicable, after the insurer receives a clean claim containing necessary medical information and other information essential for the insurer to administer preexisting condition, coordination of benefits and subrogation provisions. A “clean claim” means a claim received by an insurer for adjudication and which requires no further information, adjustment, or alteration by the provider of services or the *member* in order to be processed and paid by the insurer. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. Errors, such as system errors, attributable to the insurer, do not change the clean claim status.

A clean claim does not include any of the following:

1. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within 30 calendar days of the original claim.
2. Claims which are submitted fraudulently or that are based upon material misrepresentations.
3. Claims that require information essential for the insurer to administer preexisting condition, coordination of benefits or subrogation provisions; or
4. Claims submitted by a provider more than 30 calendar days after the date of service; if the provider does not submit the claim on behalf of the *member*, then a claim is not clean when submitted more than 30 calendar days after the date of billing by the provider to the *member*.

Not later than 25 calendar days after the date the insurer actually receives an electronic claim, the insurer shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the *member* (where the claim is owed to the *member*) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. For services that do not fall under the federal No Surprises Act *balance billing* protections, not later than 35 calendar days after the date the insurer actually receives a paper claim, the insurer shall process the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the *member* (where the claim is owed to the *member*) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by the insurer shall be processed within 20 calendar days after receipt. For services that do not fall under the federal No Surprises Act *balance billing* requirements, we will pay or deny a clean claim within 30 calendar days of receipt regardless of how the claim was submitted.

For purposes of this provision, the term “pay” means that the insurer shall either send cash or a cash equivalent by United States mail or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due the provider (where the claim is owed to the

provider) or the *member* (where the claim is owed to the *member*). To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the provider (where the claim is owed to the provider) or the *member* (where the claim is owed to the *member*) in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to the provider or *member*.

If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, the insurer must pay the provider (where the claim is owed to the provider) or the *member* (where the claim is owed to the *member*) interest on accrued benefits at the of three percent per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest is due pursuant to this provision is less than One Dollar ($1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed. The provisions of this paragraph shall not apply to any claims or benefits owed under Medicare Advantage plans or Medicare Advantage *Prescription Drug* plans.

In the event the insurer fails to pay benefits when due, the person entitled to such benefits may bring action to recover such benefits, any interest which may accrue as provided in the above paragraph of this section and any other damages as may be allowable by law. If it is determined in such action that the insurer acted in bad faith as evidenced by a repeated or deliberate pattern or failing to pay benefits and/or claims when due, the person entitled to such benefits (health care provider or *member*) shall be entitled to recover damages in an amount up to three times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

## Payment of Claims

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

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

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

When a *covered service* is received from a *non-network provider* as a result of an emergency, *members* may be responsible for amounts above the *eligible expense.*

If the *member* provides the insurer with written direction that all or a portion of any indemnities or benefits provided by the *contract* be paid to a licensed health care provider rendering *hospital*, nursing, medical or surgical services, then the insurer shall directly pay the licensed health care provider rendering such services. That payment shall be considered payment in full to the provider, who may not bill or collect from the *member* any amount above that payment, other than the *deductible*, *coinsurance*, *copayment* or other charges for equipment or services requested by the insured that are *non-covered services*. Any dispute between a provider and the insured arising under these provisions regarding assignment of benefits and billing may be resolved by the Commissioner of Insurance.

## Foreign Claims Incurred for Emergency Care

Medical emergency care is a *covered service* while traveling outside of the United States up to a maximum of 90 consecutive days. If travel extends beyond 90 consecutive days, no benefit coverage is provided for the entire period of travel including the first 90 days.

Claims incurred outside of the United States for *emergency 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 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 AmbetterHealth.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 the health plan has reviewed all the necessary documentation and the emergency claim has been processed, a member Explanation of Benefits (EOB) will be mailed. The EOB will identify *member* responsibility according to the *member's contract* at the time of travel. If services are deemed as a 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.

## Assignment

The coverage, rights, privileges, and benefits provided for under this *contract* are not assignable by you or anyone acting on your behalf, except that you may assign your benefits under this *contract* to a licensed healthcare provider that provides healthcare services to you. We shall honor any such assignments by you to a licensed healthcare provider that provides healthcare services to you for a period of one (1) year starting from the initial date of an assignment. Otherwise, any assignment or purported assignment of coverage, rights, privileges, and benefits provided for under this *contract* that you may provide or execute in favor of any *hospital*, provider, or any other person or entity shall be null and void and shall not impose any obligation on us.

## No Third-Party Beneficiaries

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

## Medicaid Reimbursement

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

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

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

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

## Custodial Parent

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

Upon request by the custodial parent, we will:

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

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

## Physical Examination

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

## Legal Actions

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

# COORDINATION OF BENEFITS

The coordination of benefits (COB) provision applies when you have health care coverage under more than one plan as stated herein.

The order of benefit determination rules govern the order 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 according to its *contract* 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

For the purpose of this section, the following definitions shall apply:

**A plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate *contracts* are used to provide coordinated coverage for *members* of a group, the separate *contracts* are considered parts of the same plan and there is no COB among those separate *contracts*.

1. Plan includes: group and non-group insurance *contracts* and *subscriber contracts*; Health maintenance organization (HMO) *contracts*; uninsured arrangements of group or group-type coverage; coverage under group or non-group closed panel plans; group-type *contracts*; medical care components of long term care *contracts*, such as skilled nursing care; medical benefits under group or individual automobile *contracts* (whether “fault” or “no fault”); other governmental benefits, except for Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2. Plan does not include: limited occurrence policies which provide only for intensive care or coronary care at a *hospital*, first aid outpatient medical expenses resulting from accidents, or specified accidents such as travel accidents; accident only coverage; specified disease or specified accident coverage; limited health benefit coverage; benefits for non-medical components of long-term care policies; *hospital* indemnity coverage benefits or other fixed indemnity coverage; school accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each *contract* for coverage under the above is a separate plan.

The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when you have 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 must make payment in an 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 equal 100 percent of the total allowable expense for that claim. This means that when this plan is secondary, it must pay the amount that which, when combined with what the primary plan paid, totals not less than the same allowable expense that this plan would have paid if it were the primary plan.

**Allowable Expense** is a health care expense, including *deductibles*, *coinsurance,* and *copayments*, that is covered at least in part by any plan covering you. 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. An expense that is not covered by any plan covering you is not an allowable expense. The following are examples of expenses that are not allowable expenses:

1. The difference between the cost of a semi-private *hospital* room and a private *hospital* room is not an allowable expense, unless one of the plans provides coverage for private *hospital* room expenses.
2. If you are covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
3. If you are covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

**Closed Panel Plan** is a plan that provides health care benefits to you in the form of services through a panel of providers who are primarily employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or *referral* by a panel member.

**Custodial Parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the *calendar year* excluding any temporary visitation.

## Order of Benefit Determination Rules

When you are covered by two or more plans, the rules for determining the order of benefit payments are as follows. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any *other plan*. A plan that does not contain a coordination of benefits provision that is consistent with Mississippi Code then it is always primary unless the provisions of both plans state that the complying plan is primary, except 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 this supplementary coverage is excess to any other parts of the plan provided by the c*ontract* holder. Examples include major medical coverage that are superimposed over *hospital* and surgical benefits, and insurance type coverage that are written in connection with a closed panel plan to provide out-of-*network* benefits. 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*. Each plan determines its order of benefits using the first of the following rules that apply.

## Non-Dependent or Dependent

The plan that covers you other than as a dependent, (for example as an employee, *member*, *contract* holder, *subscriber,* or retiree) is the primary plan and the plan that covers you as a dependent is the secondary plan. However, if you are a Medicare beneficiary or Medicaid beneficiary and, as a result of federal law, Medicare or Medicaid is secondary to the plan covering you as a dependent, and primary to the plan covering you as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering you as an employee, *member*, *contract* holder, *subscriber* or retiree is the secondary plan and the *other plan* is the primary plan.

## Child Covered Under More Than One Plan

Unless there is a court decree stating otherwise, when a child is covered by more than one plan the order of benefits is determined as follows:

1. For a 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.

2. For a 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 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. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's *spouse* does, then that parent's *spouse's* plan is the primary plan. This rule applies to claim determination periods commencing after the plan is given notice of the court decree.
   b. If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) 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 child, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits; or
   d. If there is no court decree allocating responsibility for the 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, first.
      ii. The plan covering the *spouse* of the custodial parent, second.
      iii. The plan covering the noncustodial parent, third; and then
      iv. The plan covering the *spouse* of the noncustodial parent, last.
3. For a child covered under more than one plan of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for child(ren) whose parents are married or are living together or for child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

## Active Employee or Retired or Laid-Off Employee

The plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering you as a retired or laid-off employee is the secondary plan. The same would hold true if you are a dependent of an active employee and you are 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 under the non-dependent or dependent provision above can determine the order of benefits.

## COBRA or State Continuation Coverage

If your coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering you as an employee, *member*, *subscriber,* or retiree or covering you 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 under the non-dependent or dependent provision above can determine the order of benefits.

## Longer or Shorter Length of Coverage
The plan that covered you the longer period of time is the primary plan and the plan that covered you the shorter period of time is the secondary plan. If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

## Effect on the Benefits of This Plan
When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan must make payment in an 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 are not less than the same allowable expense as the secondary plan would have paid if it was the primary plan. Total allowable expense is the highest allowable expense under this plan. In addition, the secondary plan must credit to its plan *deductible* any amounts it would have credited to its *deductible* in the absence of other health care coverage.

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

## Facility of Payment
If payments that should have been by us are made by another plan, we have the right, at our discretion, to remit to the *other plan* the amount we determine appropriate to satisfy the intent of this provision. The amounts paid to the *other plan* are considered benefits paid by us. To the extent of such payments, we are fully discharged from liability under this plan.

## Right of Recovery
We have the right to recover excess payment whenever we have paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. We may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans. If you are covered by more than one health benefit plan, and do not know which is your primary plan, you or your network provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the *other plan* to determine which is primary and will let you know within thirty calendar days.

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

When a person is eligible for Medicare benefits and Medicare is deemed to be the primary payer under Medicare secondary payer guidelines and regulations, we will reduce our payment by the Medicare primary payment and pay as secondary up to the Medicare allowable amount. However, under no circumstances will this plan pay more than it would have paid if it had been the primary plan. CAUTION: All health plans have timely claim filing requirements. If you or your provider fail(s) to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can

deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim. To avoid delays in claim processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage.

# APPEAL COMPLAINT AND GRIEVANCE PROCEDURES

## Internal Procedures:

### Applicability/Eligibility

The internal *grievance* procedures apply to any *hospital* or medical policy or certificate, but not to accident only or disability only insurance.

An eligible grievant is:

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

**Important:** *Adverse benefit determinations* that are not *grievances* will follow standard Affordable Care Act internal *appeals* processes.

## Appeals

*Appeal* means a *grievance* requesting the insurer to reconsider, reverse, or otherwise modify an *adverse benefit determination*, service, or claim.

You or your *authorized representative* have the right to file an internal *appeal* of a denial of health benefits in writing, either by mail or by facsimile (fax). For an urgent request, you may also file an *appeal* by telephone to:

Ambetter Health Solutions
ATTN: Grievance & Appeal Department
PO Box 10341
Van Nuys, CA 91410
Phone: 1-833-543-3145 (TTY 711)
Fax: 1-833-886-7956

Claimants have the right to submit written comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process.

You have up to180 calendar days to file an *appeal.* The 180 calendar days start on the date of the *adverse benefit determination.*

*Appeals* will be promptly investigated. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of an *appeal.*

### Resolution Timeframes

1. *Appeals* regarding quality of care, quality of service, or *reformation* will be resolved within 30 calendar days of receipt. The time period may be extended for an additional 14 calendar days

(making the maximum time for the entire *appeal* process 44 calendar days) if an extension is necessary, we will provide the *claimant* and the *claimant's authorized representative*, if applicable, written notification of the following within the first 30 calendar days:
    a. That we have not resolved the *appeal*.
    b. When our resolution of the *appeal* may be expected; and
    c. The reason why the additional time is needed.
2. All other *appeals* will be resolved and we will notify the *claimant* in writing with the *appeal* decision within the following timeframes:
    a. *Post-service claim*: within 60 calendar days after receipt of the *claimant*'s request for internal *appeal*.
    b. *Pre-service claim*: within 30 calendar days after receipt of the *claimant*'s request for internal *appeal*.

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

1. The claimant will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The plan will give the claimant 10 calendar days to respond to the new information before making a determination
2. The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer. The plan will give the claimant 10 calendar days to respond to the new medical rationale before making a determination.

**Expedited Appeals and Resolution Timeframe**
An *expedited appeal* may be submitted orally or in writing. All necessary information, including our determination on review, will be transmitted between the claimant and us by telephone, facsimile, or other available similarly expeditious method.

An *expedited appeal* shall be resolved as expeditiously as the *claimant*'s health condition requires but not more than 72 hours after receipt of the *appeal*.

Due to the 72-hour resolution timeframe, the standard requirements for notification, and acknowledgement do not apply to *expedited appeals*.

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

**Written Appeal Response**
*Appeal* response letters shall describe, in detail, the *appeal* procedure and the notification shall include the specific reason for the denial, determination or initiation of disenrollment.
The panel's written decision to the grievant must include:

1. The disposition of and the specific reason or reasons for the decision.
2. Any corrective action taken on the *appeal*.
3. If upheld or partially upheld, it is also necessary to include:
    a. A clear explanation of the decision.
    b. Reference to the specific plan provision on which the determination is based.
    c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant 's claim for benefits.

d. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.
e. If the *adverse benefit determination* is based on a medical necessity or *experimental treatment* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant 's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
f. Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse benefit determination*.
g. The date of service.
h. The health care provider's name.
i. The claim amount.
j. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request.
k. The health plan's denial code with corresponding meaning.
l. A description of any standard used, if any, in denying the claim.
m. A description of the external review procedures, if applicable.
n. The right to bring a civil action under state or federal law.
o. A copy of the form that authorizes the health plan to disclose protected health information, if applicable.
p. That assistance is available by contacting the specific state's consumer assistance department, if applicable; and
q. A culturally linguistic statement based upon the claimant's county or state of *residence* that provides for oral translation of the *adverse benefit determination*, if applicable.

## Complaints and Grievances

Basic elements of a *complaint*/*grievance* include:

1. The complainant is the claimant or an *authorized representative* of the claimant.
2. The submission may or may not be in writing; and
3. The issue may refer to any dissatisfaction about:
    a. Us (as the insurer); e.g., Member Services *complaints* - "the person to whom I spoke on the phone was rude to me".
    b. Providers with whom we have a direct or indirect contract:
        i. Lack of availability and/or accessibility of *network* providers not tied to an unresolved benefit denial.
        ii. Quality of care/quality of service issues.
4. Written expressions of dissatisfaction regarding quality of care/quality of service are processed as *grievances*.
5. Oral expressions of dissatisfaction regarding quality of care/quality of service are processed as *complaints* as indicated in standard oral *complaint* instructions.
6. Any of the issues listed as part of the definition of *grievance* received from the *claimant* or the claimant's *authorized representative* where the caller has not submitted a written request but calls us to escalate their dissatisfaction and request a verbal/oral review.

Attn: Grievance Department
P.O. Box 10341
Van Nuys, CA 91410
Fax: 1-833-886-7956
Telephone: 1-833-543-3145

**Acknowledgement**
Within five calendar days of receipt of an *appeal*, a written acknowledgment to the claimant or the claimant's *authorized representative* confirming receipt of the *appeal*.

Our acknowledgement to your *authorized representative* will include a clear notice stating 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*.
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*.

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

## Complaints Received From the State Insurance Department

The Commissioner of Insurance may require us to treat and process any *complaint* received by the Mississippi Department of Insurance by, or on behalf of, a claimant as a *grievance* as appropriate. We will process the Mississippi Department of Insurance's *complaint* as a *grievance* when the Commissioner of Insurance 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 claimant except to the extent the claimant has other remedies available under applicable federal or state law. We will pay for the costs of the external review performed by the independent review organization.

## Applicability/Eligibility

The g*rievance* procedures apply to:

Any *hospital* or medical policy or certificate; excluding accident only or disability income only insurance.

After exhausting the internal review process, the claimant has four months to make a written request to the State Insurance Department for external review after the date of receipt of our internal response.

1. The internal *appeal* process must be exhausted before the claimant may request an external review unless the claimant files a request for an expedited external review at the same time as an internal *expedited appeal* or we either provide a waiver of this requirement or fail to follow the *appeal* process.
2. A health plan must allow a claimant to make a request for an expedited external review with the plan at the time the claimant receives:

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

3. Claimants may request an expedited external review at the same time the internal *expedited appeal* is requested, and the State Insurance Department will determine if the internal *expedited appeal* needs to be completed before proceeding with the expedited external review.

External review is available for *appeals* that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, healthcare 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 from the State Insurance Department of the request to conduct a preliminary review of the request to determine whether:
    a. The individual was a *covered person* at the time the item or service was requested.
    b. The service is a *covered service* under the claimant's health plan but for the plan's *adverse benefit determination* with regard to medical necessity *experimental*/*investigational*, medical judgment, or *rescission*.
    c. The claimant has exhausted the internal process; and
    d. The claimant has provided all of the information required to process an external review.
2. Within one business day (immediately for expedited) after completion of the preliminary review, we will notify the claimant in writing as to whether the request is complete but not eligible for external review and the reasons for its ineligibility or, if the request is not complete, the additional information needed to make the request complete.
3. We must allow a claimant to perfect the request for external review within the four-month filing period.
4. Within one business day after receiving notice that a request is eligible for external review following the preliminary review, the State Insurance Department will assign an Independent Review Organization (IRO) to conduct the external review and will notify us of the name of the assigned IRO. The State Insurance Department will notify in writing the claimant of the request's eligibility and acceptance for review. Included in the notification to the claimant shall be a statement that the claimant may submit in writing to the assigned IRO within five business days following the date of receipt of the notice additional information that the IRO shall consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after five business days.
5. 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 benefit determination* to the

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

6. If we fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the *adverse benefit determination*.
7. Upon receipt of any information submitted by the claimant, the IRO must forward the information to us within one business day.
8. Upon receipt of the information, we may reconsider our determination. If we reverse our *adverse benefit determination*, we must provide written notice of the decision to the claimant, the State Insurance Department and the assigned IRO within one business day after making such decision. The external review would be considered terminated.
9. Within 45 days (72 hours for expedited) after the date of receipt of the request for an external review from the health plan, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to the claimant and to us. If the notice for an expedited review is not in writing, the IRO must provide written confirmation within 48 hours after the date of providing the notice.
10. Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, we will approve the *covered service* that was the subject of the *adverse benefit determination*.

| | **Timely Filing** | **Acknowledgement** | **Resolution** | **Allowable Extension** |
|---|---|---|---|---|
| Standard Grievance | 180 Calendar Days | 5 Calendar Days | 30 Calendar Days | 14 Calendar Days |
| Standard Pre-Service Appeal | 180 Calendar Days | 5 Calendar Days | 30 Calendar Days | 14 Calendar Days |
| Expedited Pre-Service Appeal | 180 Calendar Days | N/A | 72 Hours | 14 Calendar Days |
| Standard Post-Service Appeal | 180 Calendar Days | 5 Calendar Days | 60 Calendar Days | 14 Calendar Days |
| External Review | 4 months | 5 Calendar Days | 45 Calendar Days | N/A |
| Expedited External Review | 4 months | N/A | 72 Hours | N/A |

# GENERAL PROVISIONS

## Entire Contract
This *contract,* with your *Schedule of Benefits* and the application is the entire *contract* between you and us. No agent may:

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

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

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

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

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

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

## 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 www.ambetterHealth.com/privacy-practices.html or call Member Services.

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

## Language

If you don’t speak or understand the language in your area, you have the right to an interpreter. For language assistance, please visit: www.ambetterHealth.com/language-assistance.html.

| | |
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| **English:** | If you, or someone you are helping, have questions about Ambetter from Magnolia Health, and are not proficient in English, you have the right to get help and information in your language at no cost and in a timely manner. If you, or someone you are helping, have an auditory and/or visual condition that impedes communication, you have the right to receive auxiliary aids and services at no cost and in a timely manner. To receive translation or auxiliary services, please contact Member Services at 1-877-687-1187 (Relay 711). |
| **Spanish:** | Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Magnolia Health y no domina el inglés, tiene derecho a obtener ayuda e información en su idioma sin costo alguno y de manera oportuna. Si usted, o alguien a quien está ayudando, tiene un impedimento auditivo o visual que le dificulta la comunicación, tiene derecho a recibir ayuda y servicios auxiliares sin costo alguno y de manera oportuna. Para recibir servicios auxiliares o de traducción, comuníquese con Servicios para Miembros al 1-877-687-1187 (Relay 711). |
| **Vietnamese:** | Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter from Magnolia Health và không thành thạo tiếng Anh, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí và kịp thời. Nếu quý vị hoặc người mà quý vị đang giúp đỡ mắc bệnh về thính giác và/hoặc thị giác gây cản trở giao tiếp, quý vị có quyền được nhận các hỗ trợ và dịch vụ phụ trợ miễn phí và kịp thời. Để nhận dịch vụ thông dịch hoặc dịch vụ phụ trợ, vui lòng liên hệ bộ phận Dịch Vụ Thành Viên theo số 1-877-687-1187 (Relay 711). |
| **Chinese:** | 如果您，或是您正在協助的對象，有關於 Ambetter from Magnolia Health 方面的問題，且不精通英語，您有權利免費並及時以您的母語獲幫助和訊息。如果您，或您正在協助的對象有聽力和/或視力上的問題，阻礙了溝通，您有權利免費並及時獲得輔助支援與服務。若要取得翻譯或輔助服務，請聯絡會員服務部，電話是 1-877-687-1187 (Relay 711)。 |
| **French:** | Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Magnolia Health et que vous ne maîtrisez pas l'anglais, vous pouvez bénéficier gratuitement et en temps utile d'aide et d'informations dans votre langue. Si vous-même ou une personne que vous aidez souffrez d'un trouble auditif ou visuel qui entrave la communication, vous pouvez bénéficier gratuitement et en temps utile d'aides et de services auxiliaires. Pour profiter de services de traduction ou de services auxiliaires, veuillez contacter Services aux membres au 1-877-687-1187 (Relay 711). |
| **Arabic:** | إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Magnolia Health، ولم تكن بارعًا باللغة الإنكليزية، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت أنت أو أي شخص تساعده تعاني من حالة سمعية و/أو بصرية تعيق التواصل، فلديك الحق في تلقي مساعدات وخدمات إضافية من دون أي تكلفة وفي الوقت المناسب. لتلقي خدمات الترجمة أو خدمات إضافية، يرجى الاتصال بـ خدمات الأعضاء على (Relay 711) 1187-687-877-1. |
| **Choctaw:** | Chishno kiyokmat kanah kiya ish apíla kąʹ, Ambetter from Magnolia Health, imma náponaklo chim ąshakmat hicha nahollo annǫpa akostiniʹchih kaníya kiyoh ókmąʹ, alhpila\apíla hicha nán annówachi yómikąʹ chim annǫpa yǫ ish íshi kąʹ chim áyalhpísah, ná ahíka ikshoh ikmat chikkósi atahlá hiʹlah. Chishno kiyokmat kanah kiya ish apíla kąʹ, ishit haklo hicha/cho ishit pisa ayína kąʹ, isht ataklama átokósh annǫpa ik akostiniʹchoh okmąʹ ná isht apíla ýomikąʹ ish íshi áhiʹna kat chim áyalhpísah, ná ahíka iksho ikmat chikkósi atahlá hiʹlah. Annǫpa tishówa cho ná isht apila yómika ish íshi áhiʹna kąʹ, Tǫksali Alhíha ish iʹpąyakmąʹ tali anópoli holhpina pąʹ 1-877-687-1187 (Relay 711). |

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| **Tagalog:** | Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter from Magnolia Health, at hindi ka mahusay sa Ingles, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos at sa maagap na paraan. Kung ikaw, o ang iyong tinutulungan, ay may kondisyon sa pandinig at/o pannikin na nakakaapekto sa komunikasyon, may karapatan kang makatanggap ng mga karagdagang tulong at serbisyo nang walang gastos at sa maagap na paraan. Para makatanggap ng mga serbisyo sa pagsasalin o mga karagdagang serbisyo, mangyaring makipag-ugnayan sa Mga Serbisyo para sa Miyembro sa 1-877-687-1187 (Relay 711). |
| **German:** | Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Magnolia Health hat und nicht Englisch spricht, haben Sie das Recht, kostenlos und zeitnah Hilfe und Informationen in Ihrer Sprache zu erhalten. Falls Sie oder jemand, dem Sie helfen, eine Hör- und/oder Sehbeeinträchtigung hat, die die Kommunikation beeinflusst, haben Sie das Recht, kostenlos und zeitnah zusätzliche Hilfe und Dienstleistungen zu erhalten. Um eine Übersetzung oder zusätzliche Dienstleistungen zu erhalten, wenden Sie sich an den Kundendienst unter 1-877-687-1187 (Relay 711). |
| **Korean:** | 귀하 또는 귀하의 도움을 받는 분이 Ambetter from Magnolia Health에 대한 질문이 있는 경우 영어에 능숙하지 않으시면 해당 언어로 시의적절하게 무료 지원과 정보를 받을 권리가 있습니다. 귀하 또는 귀하의 도움을 받는 분이 청각 및/또는 시각적으로 의사소통에 장애가 있는 경우 시의적절하게 무료 보조 도구 및 서비스를 받을 권리가 있습니다. 번역 또는 보조 서비스를 받으시려면 1-877-687-1187 (Relay 711)번으로 가입자 서비스부에 연락해주십시오. |
| **Gujarati:** | જો તમને અથવા તમે જેમની મદદ કરી રહ્યા હો એવી કોઈ વ્યક્તિને Ambetter from Magnolia Health વિશે પ્રશ્નો હોય અને અંગ્રેજીમાં પ્રવીણ ન હોય, તો તમને કોઈ ખર્ચ કર્યા વિના અને સમયસર તમારી ભાષામાં મદદ તથા માહિતી મેળવવાનો અધિકાર છે. જો તમે અથવા તમે જેમની મદદ કરી રહ્યા હો એવી કોઈ વ્યક્તિ શ્રવણશક્તિ અને/અથવા દૃષ્ટિવિષયક અવસ્થાથી પીડિત હોય કે જે સંચારને અવરોધતી હોય, તો તમને કોઈ ખર્ચ કર્યા વિના અને સમયસર સહાયક સહાય તથા સેવાઓ પ્રાપ્ત કરવાનો અધિકાર છે. અનુવાદ અથવા સહાયક સેવાઓ પ્રાપ્ત કરવા માટે, કૃપા કરીને 1-877-687-1187 (Relay 711) પર સભ્યની સેવાઓનો સંપર્ક કરો. |
| **Japanese:** | ご自身やあなたが介護している他の人が、Ambetter from Magnolia Healthについてご質問をお持ちの場合、英語に自信がなくても無料かつタイムリーにご希望の言語でヘルプや情報を得ることができます。ご自身や、あなたが介護している他の人の聴覚や視覚の状態のためやり取りが難しい場合でも、無料かつタイムリーに補助サービスを受けることができます。翻訳や補助サービスを受けるには、1-877-687-1187 (Relay 711)のメンバーサービスにご連絡ください。 |
| **Russian:** | Если у вас или у лица, которому вы помогаете, возникли какие-либо вопросы о программе страхования Ambetter from Magnolia Health, при этом вы недостаточно хорошо владеете английским языком, вы имеете право на бесплатную и своевременную помощь и информацию на своем родном языке. Если у вас или у лица, которому вы помогаете, наблюдается какое-либо нарушение слуха и/или зрения, которое препятствует коммуникации, вы имеете право на бесплатные и своевременные вспомогательные услуги и помощь. Для получения услуг перевода или вспомогательных услуг обратитесь в отдел обслуживания участников программы страхования по номеру 1-877-687-1187 (Relay 711). |

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| **Panjabi:** | ਜੇ ਤੁਸੀਂ, ਜਾਂ ਤੁਹਾਡੇ ਦੁਆਰਾ ਮਦਦ ਕੀਤੇ ਜਾਣ ਵਾਲੇ ਕਿਸੇ ਵਿਅਕਤੀ ਦੇ Ambetter from Magnolia Health ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ, ਅਤੇ ਤੁਸੀਂ ਅੰਗਰੇਜ਼ੀ ਵਿੱਚ ਮੁਹਾਰਤ ਨਹੀਂ ਰੱਖਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਦੇ ਅਤੇ ਸਮੇਂ ਸਿਰ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਜੇ ਤੁਹਾਨੂੰ, ਜਾਂ ਤੁਹਾਡੇ ਦੁਆਰਾ ਮਦਦ ਕੀਤੇ ਜਾਣ ਵਾਲੇ ਕਿਸੇ ਵਿਅਕਤੀ ਨੂੰ ਸੁਣਨ ਅਤੇ/ਜਾਂ ਦੇਖਣ ਸੰਬੰਧੀ ਕੋਈ ਸਮੱਸਿਆ ਹੈ, ਜੋ ਸੰਚਾਰ ਵਿੱਚ ਰੁਕਾਵਟ ਪਾਉਂਦੀ ਹੈ, ਤਾਂ ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਅਤੇ ਸਮੇਂ ਸਿਰ ਸਹਾਇਕ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਅਨੁਵਾਦ ਜਾਂ ਸਹਾਇਕ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ 1-877-687-1187 (Relay 711) 'ਤੇ ਮੈਂਬਰ ਸੇਵਾਵਾਂ ਨਾਲ ਸੰਪਰਕ ਕਰੋ। |
| **Italian:** | Se Lei o una persona a cui sta fornendo assistenza ha domande su Ambetter from Magnolia Health e non ha una perfetta padronanza della lingua inglese, ha il diritto di ricevere aiuto e informazioni nella Sua lingua gratuitamente e tempestivamente. Se Lei o una persona a cui sta fornendo assistenza presenta una condizione uditiva e/o visiva che impedisce la comunicazione, ha il diritto di ricevere servizi ausiliari gratuitamente e tempestivamente. Per ricevere una traduzione o un servizio ausiliario, contatti i Servizi per i membri al numero 1-877-687-1187 (Relay 711). |
| **Hindi:** | अगर आप या कोई ऐसा व्यक्ति जिसकी आप सहायता कर रहे हैं, के पास Ambetter from Magnolia Health से जुड़े प्रश्न हैं और आप दोनों अंग्रेज़ी में माहिर नहीं हैं, तो आपको अपनी भाषा में मुफ़्त और समय पर सहायता और जानकारी प्राप्त करने का अधिकार है. अगर आपको या किसी ऐसे व्यक्ति को जिसकी आप मदद कर रहे हैं, सुनने और/या देखने में समस्या होती है और इससे बातचीत बाधित होती है, तो आपको बिना किसी लागत के और समय पर सहायक सहायता और सेवाएं प्राप्त करने का अधिकार है. अनुवाद या सहायक सेवाएं प्राप्त करने के लिए कृपया 1-877-687-1187 (Relay 711) पर सदस्य सेवाएं से संपर्क करें. |