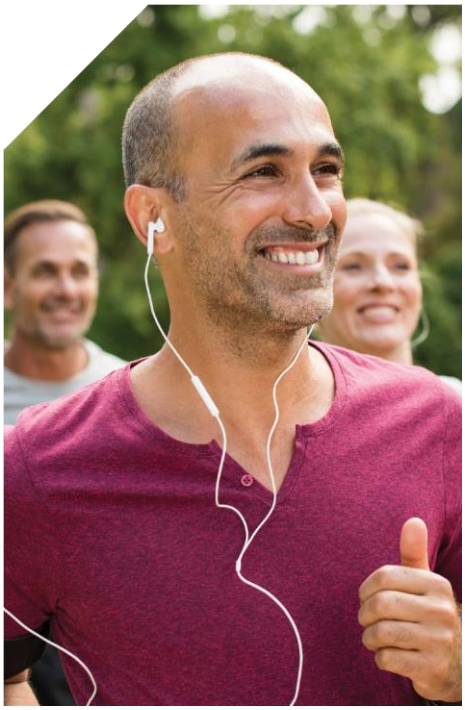
ambetter HEALTH OF delaware



2025 EVIDENCE OF COVERAGE

64004DE009-2025

AmbetterHealthofDelaware.com

Ambetter Health of Delaware

Home Office: 200 East Randolph, Suite 3600, Chicago, IL 60601

Major Medical Expense Insurance Policy

In this *policy,* the terms *"*you*"* or "your" will refer to the *member* or any *dependent members* named in the enrollment application. The terms *"*we*," "*our*,"* or "us*"* will refer to Ambetter Health of Delaware.

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

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

1. We decide not to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where you then live;
2. We withdraw from the *service area;* or
3. There is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *policy* benefits.

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

At least 60 calendar days' notice of any plan to take an action or make a change permitted by this clause will be delivered to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under this *policy* or a change in a *member's* health. While this *policy* is in force, we will not restrict coverage already in force. If we discontinue offering and decide not to renew all 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 *policy* contains *prior authorization* requirements. You may be required to obtain a referral from a *primary care physician (PCP)* in order to receive care from a *specialist physician*. Benefits may be reduced or not covered if the requirements are not met. Please refer to your *Schedule of Benefits* and the PRIOR AUTHORIZATION section.

TEN DAY RIGHT TO RETURN POLICY

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

Celtic Insurance Company

Kevin J. Counihan, President

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INTRODUCTION

Welcome to Ambetter Health of Delaware! This *policy* has been prepared by us to help explain your coverage. Please refer to this *policy* whenever you require medical services.

It describes:

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

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

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

How to Contact Us
Ambetter Health of Delaware
750 Prides Crossing, Suite 200
Newark, DE 19713

Normal Business Hours of Operation: 8:00 a.m. to 8:00 p.m. local time
Member Services: 1-833-919-3214
TTY line: Relay 711
Fax: 1-855-227-3804
Emergency: **911**
24/7 Nurse Advice Line: 1-833-919-3214 or for the hard of hearing (TTY Relay 711)

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

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

To arrange for interpreter services, please call Member Services.

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

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

You have the right to:

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

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

    Members also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive.

You have the responsibility to:

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

IMPORTANT INFORMATION

Provider Directory

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

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

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

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

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

Member Identification Card

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

Website

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

1. Finding a *network provider*, including *hospitals* and pharmacies.
2. Our programs and services, including programs to help you get and stay healthy.
3. A secure portal for you to check the status of your claims, make payments and obtain a copy

of your *member* identification card.
4. Member Rights and Responsibilities.
5. Notice of Privacy Practices.
6. Current events and news.
7. Our Formulary or Prescription Drug List.
8. *Deductible* and *copayment* accumulators.
9. Selecting a *PCP*.

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

Quality Improvement

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

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

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

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

Protection from Balance Billing

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

DEFINITIONS

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

Wherever used in this *policy*:

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

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

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

Adverse 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 or investigational, cosmetic treatment,* not *medically necessary* or inappropriate.
5. A denial of coverage based upon an eligibility determination.
6. A determination that *balance billing protections* do not apply to a service.
7. An incorrectly calculated amount of *cost sharing* a *member* owes when *balance billing protections* apply.
8. A *rescission* of coverage determination as described in the GENERAL PROVISIONS section of this *policy.*
9. A prospective review or retrospective review determination that denies, reduces or fails to provide or make payment, in whole or in part, for a *covered service*.

Refer to the APPEAL AND GRIEVANCE PROCEDURES section of this *policy* for information on your right to *appeal* an *adverse benefit determination.*

Allowed amount (also see ***"Eligible expense"***) means the maximum amount we will pay a provider for a *covered service*. When a *covered service* is received from a *network provider*, the *allowed amount* is the amount the provider agreed to accept from us as payment for that particular service. In all cases, the *allowed amount* will be subject to *cost sharing* (e.g., *deductible amount*, *copayment amount* and *coinsurance amount*) per the *member's* benefits. This amount excludes any payments made to the provider by us as a result of federal or state arbitration. In the event a provider exercises an available right to arbitration to recover additional payment, the *member cost sharing* will be calculated on the original *allowed amount*.

Note: If you receive services from a *non-network provider*, you may be responsible for the difference between the amount the provider charges for the service (*billed amount*) and the *allowed amount* that we pay. However, you will not be responsible for *balance billing* for non-network care that is subject to *balance billing protections* and otherwise covered under your *policy.* See ***Balance billing, Balance billing protections*** and ***Non-network provider*** definitions for additional information. If you are *balanced billed* in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Center of Excellence means a *hospital* that:

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

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

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

Complications of pregnancy means:

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

Continuing care patient means an individual who, with respect to a provider or facility:

1. Is undergoing a treatment for a *serious and complex condition* from that provider or facility;
2. Is undergoing a course of institutional or *inpatient* care from that provider or facility;
3. Is scheduled to undergo non-elective *surgery* from that provider, including postoperative care;
4. Is pregnant and undergoing a course of treatment for the *pregnancy*; or
5. Is or was determined to be *terminally ill* and is receiving treatment for such *illness*.

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

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

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

Cost sharing reductions mean the reduction in the amount you have to pay in *deductible amounts*, *copayment amounts* and *coinsurance amounts.* 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(s) means services, supplies or treatment as described in this *policy* which are performed, prescribed, directed or authorized by a *physician.* To be a *covered service* the service, supply or treatment must be:

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

Custodial care means the 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.

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

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

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

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

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

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

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

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

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

Eligible child means the child of a *primary subscriber* if that child is less than 26 years of age. If an *eligible child* turns 26 during the plan year, they remain an *eligible child* through the end of the plan year. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child;
3. A child placed with you for adoption;
4. A foster child placed in your custody;
5. A child for whom legal guardianship has been awarded to you or your *spouse* or domestic partner; or
6. A stepchild.

It is your responsibility to notify the entity that you enrolled with (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* as determined below.

1. For *network providers*: When a *covered service* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.
2. For *non-network providers*, unless otherwise required by federal or Delaware law, the *eligible expense* is as follows:
    a. When *balance billing protections* apply to a *covered service* received from a *non-network provider,* the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full. If the provider has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by *applicable law*, the *eligible expense* is reimbursement as determined by us and as required by *applicable law*.
    b. For all other *covered services* received from a *non-network provider* for which any needed *authorization* is received from us, the *eligible expense* is 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 *behavioral health* condition manifesting itself by acute systems of sufficient severity (including severe pain) that a prudent layperson who possess average knowledge of health and medicine, could reasonably expect the absences 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 a serious jeopardy physical or *behavioral 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 mean *covered services* needed to evaluate and *stabilize* an *emergency condition*. This includes a medical screening examination in a *hospital* emergency department (including labor and delivery departments) 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, *physician* services and supplies and *prescription drugs* charged by that facility. You must notify us or verify that your *physician* has notified us of your admission to a *hospital* within 48 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the *inpatient* setting is appropriate, and if appropriate, the number of days considered *medically necessary*. By contacting us, you may avoid financial responsibility for any *inpatient* care that is determined to be not *medically necessary* under your *policy*. If your provider does not contract with us, you will be financially responsible for any care we determine is not *medically necessary*. Care and treatment provided once you are *stabilized* is no longer considered *emergency services* under your *policy*. Continuation of care beyond what is needed to evaluate or *stabilize* your condition in an emergency will not be a *covered service* unless we *authorize* the continuation of care and it is *medically necessary*.

Enhanced direct enrollment or ***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 (www.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 *physician* with knowledge of the claimant's medical condition, the claimant is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*.
3. A *physician* with knowledge of the claimant's medical condition determines that the *grievance* shall be treated as an *expedited grievance*.

Experimental or investigational means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, we determine to be any of the following:
1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (FDA) regulation, regardless of whether the trial is subject to FDA oversight.
2. An *unproven service.*

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

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

Extended care facility or ***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.

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

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

Grievance means an expression of dissatisfaction about any matter other than an *adverse benefit determination*. It may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the *member's* rights regardless of whether remedial action is requested. A *grievance* includes a *member's* right to dispute an extension of time proposed by us to make an *authorization* decision.

Habilitation or ***habilitation services*** mean health care services that helps a patient keep, learn or improve skills and functioning for daily living. These services may be performed in an *inpatient* or

outpatient setting and include physical therapy, occupational therapy and speech-language pathology and other services for people with disabilities in a variety of *inpatient* or outpatient settings.

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

Home health care means care or treatment of an *illness* or *injury* at the *member's* home that is:
1. Provided by a *home health care agency*; and
2. Prescribed and supervised by a *physician*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medical practitioner includes but is not limited to a *physician*, nurse anesthetist, physician's assistant, physical therapist or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* acupuncturist, 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 those *covered services*, items or supplies that:

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

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

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

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

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

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

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

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

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

Non-elective cesarean section means:

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

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

1. *Emergency services*, as described in the MAJOR MEDICAL EXPENSE BENEFITS section of this *policy;*
2. Non-emergency health care services received at a *network* facility, as described in the ACCESS TO CARE section of this *policy;*
3. Air ambulance services; and
4. Situations otherwise specifically described in this *policy.*

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

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

Notice and consent will not waive *balance billing protections* for *emergency services*, air ambulance services, services furnished due to unforeseen and urgent medical needs, services provided by a *non-network provider* when there is no *network provider* available at the facility or ancillary services (which are services related to emergency medicine, anesthesiology, pathology, radiology and

neonatology; diagnostic services such as radiology and laboratory services; and services provided by non-physician practitioners, assistant surgeons, hospitalists, and intensivists). *Notice and consent* will waive *balance billing protections* for *post-stabilization services* only if all the following additional conditions are met:

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

Orthotic device means a *medically necessary* custom fabricated brace or support that is designed as a component of a *prosthetic device*.

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

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

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

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

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

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

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

Post-stabilization services mean services furnished after a *member's emergency condition* is *stabilized* and as part of outpatient observation or an *inpatient* or *outpatient stay* 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 the *Schedule of Benefits*, if applicable, that must actually be paid during any *calendar year* before any *prescription drug* benefits are payable. The family *prescription drug deductible amount* is two times the individual *prescription drug deductible amount*. For family coverage, once a *member* has met the individual *prescription drug deductible amount*, any remaining family *prescription drug deductible amount* can be met with the combination of any one or more *member's eligible expenses*.

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

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

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

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

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

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

Qualified health plan or ***QHP*** means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Health Insurance

Marketplace through which such plan is offered in accordance with the process described in subpart K of part 155.

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

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

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

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

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

Rehabilitation facility does not include a facility primarily for rest, the aged, long-term care, assisted living, *custodial care,* nursing care or for care of an individual with an intellectual disability.

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

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

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

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

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

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

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

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

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

Serious 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 Delaware to sell and market our health plans. This is where the majority of our *network providers* are located where you will receive all of your health care services and supplies. You can receive precise *service area* boundaries from our website or Member Services.

Skilled nursing facility or ***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 mean the circumstances in which people are born, grow up, live, work and age. This also includes the systems in place to offer health care and services to a community.

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

Spouse means your lawful wife or husband.

Stabilize means, with respect to a *member* who has not experienced an *emergency condition*, that the *member* is no longer experiencing further deterioration as a result of a prior *illness* or *injury* and there are no acute changes in physical findings, laboratory results or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*. *Stabilize*, with respect to a *member* who has experienced an *emergency condition*, means to provide medical

treatment of the condition as necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer* of the *member* to another facility or discharge of the *member* (*See **Ambulance Services Benefits** provision under the MAJOR MEDICAL EXPENSE BENEFITS section).

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

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 means an individual who, as part of a *surrogacy arrangement*:
1. Uses her own egg that is fertilized by a donor; or
2. Is a gestational carrier who has a fertilized egg placed in her body but the egg is not her own.

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

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

Telemedicine services mean health care services delivered by use of interactive audio, video or other electronic media, including the following:
1. Medical examinations and consultations; and
2. *Behavioral health*, including *substance use disorder* evaluations and treatment.

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

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

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

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

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

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

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

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

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

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

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

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

Effective Date for Initial Dependent Members

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

Coverage for a Newborn Child

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

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

Coverage for an Adopted Child

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

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

Additional premium will be required to continue coverage beyond the 31st day following placement of the child and we have received notification from the Marketplace. The required premium will be calculated from the date of placement for adoption. Coverage of the child will terminate on the 31st day following placement, unless we have received both:

1. Notification of the addition of the child from the Marketplace within 60 calendar days of the birth or placement; and
2. 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* assumes 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*.

ONGOING ELIGIBILITY

For All Members

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

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

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

For Dependent Members

A *dependent member* will cease to be a *member* at the end of the premium period in which he or she ceases to be your *dependent member* due to divorce or if a child ceases to be an *eligible child.* For *eligible children*, the coverage will terminate the 31st day of December the year the *dependent member* turns 26 years of age.

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

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

Open Enrollment

There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 1, 2024 and extends through January 15, 2025. *Qualified individuals* who enroll on or before 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 Health Insurance Marketplace or by using Ambetter's *Enhanced Direct Enrollment* tool. If a *qualified individual* loses Medicaid or CHIP coverage that is considered *minimum*

essential coverage, they have up to 90 calendar days after the loss of *minimum essential coverage* to enroll in a Marketplace plan. *Qualified individuals* may be granted a Special Enrollment Period where they may enroll in or change to a different Marketplace plan during the current plan year if they have a qualifying event. Qualifying events include:

1. A *qualified individual* or *dependent member* experiences a loss of *minimum essential coverage*, non-calendar year group or individual health insurance coverage, pregnancy-related coverage, access to health care services through coverage provided to a pregnant enrollee's unborn child or medically needed coverage.
2. A *qualified individual* gains a *dependent member* or becomes a *dependent member* through marriage, birth, adoption, placement for adoption, placement in foster care or a child support order or other court order. In the case of marriage, at least one *spouse* must demonstrate having *minimum essential coverage* as described in 26 CFR 1.5000A-1(b) for one or more days during the 60 calendar days preceding the date of marriage.
3. A *qualified individual* or *dependent member*, 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 member* adequately demonstrates to the Health Insurance Marketplace that the plan in which he or she is enrolled substantially violated a material provision of its *policy* in relation to the enrollee.
6. A *qualified individual*, enrollee or *dependent member* 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 member* enrolled in the same plan is determined newly eligible or newly ineligible for *advance premium tax credits* or has a change in eligibility for *cost sharing reductions*.
8. A *qualified individual* or *dependent member* who is enrolled in an eligible employer-sponsored plan is determined newly eligible for *advance premium tax credits* based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-2(c)(3).
9. A *qualified individual*, enrollee or *dependent member* gains access to new *QHPs* as a result of a permanent move, and had *minimum essential coverage* as described in 26 CFR 1.5000A–1(b) for one or more days during the 60 calendar days preceding the date of the permanent move.
10. A *qualified individual* or *dependent member* 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 us, in accordance with guidelines issued by Health and Human Services (HHS), that the individual meets other exceptional circumstances as may be provided.
12. A *qualified individual*, enrollee or *dependent member* 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 member* is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60

calendar days after the qualifying event; or applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended.

14. A *qualified individual* newly gains access to an employer sponsored Individual Coverage Health Reimbursement Arrangement (ICHRA) (as defined in 45 CFR 146.123(b)) or a Qualified Small Employer Health Reimbursement Arrangement (QSHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code).
15. At the option of the Health Insurance Marketplace, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a plan through the Health Insurance Marketplace following termination of enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national or lawful presence.
16. A *qualified individual* or *dependent member* is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions or government subsidies completely cease.
17. Subject to the availability of enhanced tax subsidies, a *qualified individual* or enrollee, or their dependent who is eligible for advance payments of the premium tax credit, and whose household income is expected to be no greater than 150 percent of the federal poverty level.

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

If you are currently enrolled in Ambetter Health of Delaware, 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, *policy* violation or exceptional circumstances, coverage is effective on an appropriate date based on the circumstances of the special enrollment period, in accordance with guidelines issued by the Department of Health and Human Services. Such date must be either:

1. The date of the event that triggered the special enrollment period; or
2. In accordance with the regular effective dates.

If a *qualified individual*, enrollee or *dependent member* 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 member* 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 member* 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 member* to select a new plan within 60 calendar days of the date that he or she knew, or reasonably should have known, of the occurrence of the triggering event. And at the option of a *qualified individual*, enrollee or *dependent member*, the Health Insurance Marketplace must provide the earliest effective that would have been available, based on the applicable qualifying event.

Prior Coverage

If a *member* is confined as an *inpatient* in a *hospital* on the *effective date* of this *policy* and prior coverage is terminating immediately before the *effective date* of this *policy* furnishes benefits for the hospitalization will start at the end of 10 consecutive days of hospitalization under this *policy* at the level provided by this *policy* notwithstanding any preexisting conditions or other similar exclusions for the duration of the single continuing period of hospitalization.

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

PREMIUMS

Premium Payment

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

Grace Period

When a *member* is receiving a premium subsidy:

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

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

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

Third Party Payment of Premiums or Cost Sharing

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

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

2. Indian tribes, tribal organizations or urban Indian organizations;
3. State and federal government programs;
4. Certain tax-exempt organizations;
5. Family members;
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*; or
7. An employer for an employee under an Individual Coverage Health Reimbursement Account (ICHRA) or Qualified Small Employer Health Reimbursement Account (QSEHRA) plan.

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

Misstatement of Age

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

Change or Misstatement of Residence

If you change your *residence*, you must notify the Health Insurance Marketplace of your new *residence* within 60 calendar days of the change. As a result, your premium may change and you may be eligible for a special enrollment period. See the **Special Enrollment Periods** provision in the ONGOING ELIGIBILITY section for more information.

Misstatement of Tobacco or Nicotine Use

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

PRIOR AUTHORIZATION

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

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

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

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

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

1. At least five calendar days prior to an elective admission as an *inpatient* in a *hospital*, *extended care facility, rehabilitation facility*, *hospice* facility or *residential treatment facility*.
2. At least 30 calendar days prior to the initial evaluation for organ transplant services.
3. At least 30 calendar days prior to receiving clinical trial services.
4. Within 24 hours of an admission for *inpatient* mental health or *substance use disorder* treatment.
5. At least five calendar days prior to the start of *home health care*.

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 24 hours (one calendar day) of receipt of the request.
2. For urgent pre-service reviews, within 72 hours (three calendar days) of receipt of the request.
3. For non-urgent pre-service reviews within five business days of receipt of a clean pre-authorization, if the request is submitted electronically.
4. For non-urgent pre-service reviews, within eight business days of receipt of a clean pre-authorization, if the request is not submitted electronically.
5. For post-service or retrospective reviews, within 30 calendar days 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*.

Note: A clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

You do not need to obtain *prior authorization* from us or from any other person (including your *PCP*) in order to obtain access to obstetrical or gynecological care from a *medical practitioner* in our network who specializes in obstetrics or gynecology. The *medical practitioner*, however, may be required to comply with certain procedures, including obtaining *prior authorization* for certain services, following a pre-approved treatment plan or procedures for making referrals. For a list of participating *medical practitioners* who specialize in obstetrics or gynecology, contact Member Services.

How to Obtain Prior Authorization

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

Failure to Obtain Prior Authorization

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

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

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

Prior Authorization Does Not Guarantee Benefits

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

Requests for Predeterminations

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

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

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

Services from Non-Network Providers

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

COST SHARING FEATURES

Cost Sharing Features

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

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

Deductible

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

Copayments

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

Coinsurance Percentage

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

Maximum Out-of-Pocket

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

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

When the annual *maximum out-of-pocket amount* has been met, additional *covered services* will be provided or payable at 100 percent of the *allowed amount*. The amount provided or payable will be subject to:

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

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

Non-Network Liability and Balance Billing

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

Health Savings Account (HSA)

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

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

This Evidence of Coverage is administered by Ambetter Health of Delaware and underwritten by Celtic Insurance Company. Neither entity is an HSA trustee, HSA custodian or a designated administrator for HSAs. Celtic Insurance Company, its designee and its affiliates, including Ambetter Health of Delaware, 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 ALLOWABLE AMOUNT, CONTRIBUTIONS AND QUALIFIED WITHDRAWALS. IN ADDITION, EACH *MEMBER* WITH AN HSA IS RESPONSIBLE FOR NOTIFYING HIS/HER HSA CUSTODIAN OR TRUSTEE IF ENROLLMENT UNDER THEIR HSA PLAN HAS BEEN CANCELED OR TERMINATED.

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

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

ACCESS TO CARE

Primary Care Physician (PCP)

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

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

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

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

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

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

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

Contacting Your Primary Care Physician (PCP)

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

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

Should you need care outside of your *PCP's* office hours, you should call your *PCP's* office for information on receiving after hours care in your area. If you have an urgent medical problem or question or cannot reach your *PCP* during normal office hours, call our 24/7 nurse advice line at 1-833-919-3214 (TTY Relay 711). A licensed nurse is always available and ready to answer your health questions. In an emergency, call 911 or head straight to the nearest emergency room.

Changing Your Primary Care Physician (PCP)

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

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

Coverage Under Other Policy Provisions

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

Non-Emergency Services

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

Emergency Services Outside of Service Area

We cover *emergency services* when you are outside of our *service area*.

If you are temporarily out of the *service area* and experience an *emergency condition*, call 911 or go the nearest emergency room. Be sure to a call us and report your emergency within one business day. You do not need *prior authorization* for *emergency services*.

Continuity of Care

Under the federal No Surprises Act, if a *member* is a *continuing care patient* with respect to a *network provider* and the contractual relationship with the provider is terminated, such that the provider or facility 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 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 calendar 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.

Hospital Based Providers

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

New Technology

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

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

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

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

Preferred Partnership

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

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

MAJOR MEDICAL EXPENSE BENEFITS

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

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

Acquired Brain Injury Services

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

1. Cognitive *rehabilitation therapy*
2. Cognitive communication therapy
3. Neurocognitive therapy and *rehabilitation*
4. Neurobehavioral, neuropsychological, 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.

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 *policy*.

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

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

Ambulance Services Benefits

Air Ambulance Service Benefits

Covered services will include ambulance services (including volunteer services) for transportation by fixed wing and rotary wing air ambulance from home, scene of accident or *emergency condition,* subject to other coverage limitation described 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, when *authorized* by us.
4. When ordered by an employer, school, fire or public safety official and the *member* is not in a position to refuse.
5. When a *member* is required by us to move from a *non-network provider* to a *network provider*.

Non-emergency air ambulance transportation requires *prior authorization*. *Prior authorization* is not required for air ambulance transportation when the *member* is experiencing an *emergency condition*.
Note: You should not be *balance billed* for covered air ambulance services.

Limitations: Benefits for air ambulance services are limited to:

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

Exclusions:
No benefits will be paid for:

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

Ground and Water Ambulance Service Benefits

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

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

2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects or complications of premature birth that require that level of care.
3. Transportation between *hospitals* or between a *hospital* and a more appropriate level of care, when *authorized* by us.
4. When ordered by an employer, school, fire or public safety official and the *member* is not in a position to refuse.
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 Delaware law, if you receive services from non-network ambulance providers, you may be *balance billed*.

Exclusions:
No benefits will be paid for:
1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Ambulance services provided for a *member's* comfort or convenience.
3. Non-emergency transportation (for example, transport-van, taxi, ride sharing).

Autism Spectrum Disorder Benefits

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

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 amount* and/or *coinsurance amount* will apply to each provider.

Care Management Programs

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

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

Your care manager will work with you and your doctor to help you get the care you need. If you have a severe medical condition, your care manager will work with you, your *PCP* and other providers to develop a care plan that meets your needs and your caregiver's needs.

If you think you could benefit from our *care management* program, please call Member Services.

Clinical Trial Coverage

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

1. drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition,
2. reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial and
3. all items and services that are otherwise generally available to a *qualified individual* that are provided in the clinical trial except:
    a. The investigational item or service itself;
    b. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
    c. Items and services customarily provided by the research sponsors free of charge for any *member* in the trial.

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

1. Phase I and II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and
2. The *member* is enrolled in the clinical trial. This section shall not apply to *members* who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

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

1. One of the National Institutes of Health (NIH);
2. The Centers for Disease Control and Prevention;
3. The Agency for Health Care Research and Quality;
4. The Centers for Medicare & Medicaid Services;
5. An NIH Cooperative Group or Center;
6. The FDA in the form of an investigational new drug application;
7. The federal Departments of Veterans' Affairs, Defense or Energy;
8. An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects; or

9. A qualified non-governmental research entity that meets the criteria for NIH Center support grant eligibility.

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

Providers participating in clinical trials shall obtain a patient's informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards. Participation in clinical trials is subject to *prior authorization* requirements as outlined in this *policy*.

Diabetic Care

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

Covered services 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, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles.
5. Orthotics and diabetic shoes.
6. Urinary protein/microalbumin and lipid profiles.
7. Educational health and nutritional counseling for self-management, eye examinations, prescription medications and retinopathy examination screenings, as *medically necessary*.

Benefits are available for *medically necessary* items of diabetic supplies and equipment, including, but not limited to, blood glucose monitors (including non-invasive monitors and monitors for the blind) for which a *medical practitioner* has written an order. Benefits are also available at no cost to the *member* for *medically necessary* insulin pumps. Pursuant to state regulation, the $0 *cost share* for insulin pumps does not apply to *members* enrolled in an HSA-eligible plan. Please review your *Schedule of Benefits* to determine if your plan is HSA-eligible.

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

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 services include:

1. Services provided in an outpatient dialysis facility or when services are provided in the home;
2. Processing and administration of blood or blood components;
3. Dialysis services provided in a *hospital*; and

4. Dialysis treatment of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

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

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

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

1. The equipment, supply or appliance is a *covered service*.
2. The continued use of the item is *medically necessary*.
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.

<u>Disposable Medical Supplies</u>

Disposable medical supplies, which have a primary medical purpose, are covered and are subject to reasonable quantity limits as determined by us. Examples include, but are not limited to, bandages and wraps, gloves, suction catheters, surgical sponges, hypodermic needles, syringes and

applicators. The supplies are subject to the *member's* medical *deductible amount*, *copayment amount* and/or *coinsurance amount*.

Durable Medical Equipment

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

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

1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for intravenous (I.V.) 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/coldpack pump.
3. Raised toilet seats.
4. Rental of equipment if the *member* is in a facility that is expected to provide such equipment.
5. Translift chairs.
6. Treadmill exerciser.
7. Tub chair used in shower.

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

Medical and Surgical Supplies

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

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

1. Allergy serum extracts.
2. Chem strips, glucometer, lancets.

3. Clinitest.
4. Needles/syringes.
5. Ostomy bags and supplies, except charges such as those made by a pharmacy for purposes of a fitting, are not *covered services*.

Exclusions:
Non-covered services and supplies include, but are not limited to:
1. Adhesive tape, band aids, cotton tipped applicators.
2. Arch supports.
3. Doughnut cushions.
4. Hot packs, ice bags.
5. Vitamins (except as provided for under **Preventive Care Expense Benefits** provision).
6. Medijectors.
7. Items usually stocked in the home for general use like band aids, thermometers and petroleum jelly.

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

Covered *orthotic devices* and supplies may include, but are not limited to, the following:
1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.
10. Devices for correction of positional plagiocephaly.
11. Orthopedic shoes.
12. Standard elastic stockings

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

Exclusions:
Non-covered services and supplies include, but are not limited to:
1. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
2. Garter belts and other supplies not specifically made and fitted (except as specified under the Medical and Surgical Supplies provision above).

Prosthetic Devices

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

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

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

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

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

Exclusions:

Non-covered *prosthetic devices* 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 when medical necessity criteria are not met or is strictly a cosmetic procedure.

Family Planning and Contraception

Family planning/contraception benefits are covered under preventive care, without *cost sharing* when provided by a *network provider*, when 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 Health Resources and Services Administration (HRSA):

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

Fertility/Infertility Preservation

For individuals who qualify under Delaware law, *covered services* include fertility care services, including in vitro fertilization services, identified in 18 Del. C. § 3342 for individuals who suffer from a disease or condition that results in the inability to procreate or to carry a *pregnancy* to live birth and standard fertility preservation services for individuals who must undergo *medically necessary* treatment that may cause iatrogenic infertility. Experimental fertility care services, monetary payments to gestational carriers or *surrogates*, and reversals of voluntary sterilization are not *covered services*.

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

See 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*.

Hearing Aid Benefits
Benefits are available for hearing aids when *medically necessary* and obtained from a *network provider*. This benefit is limited to one hearing aid for each ear with hearing loss every 36 months. The hearing aid must be fitted and dispensed by a licensed audiologist, licensed hearing aid specialist or a hearing aid dealer after the medical clearance of a *physician* and an audiological evaluation.

Home Health Care Service Expense Benefits
Covered services and supplies for *home health care* are covered when your *physician* indicates you are not able to travel for appointments to a medical office. Coverage is provided for *medically necessary network* care provided at the *member's* home and includes the following:
1. *Home health aide services*.
2. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to your *Schedule of Benefits* for any limits associated with this benefit.
3. Professional fees of a licensed respiratory, physical, occupational or speech therapist required for *home health care.*
4. Intravenous medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental of *medically necessary durable medical equipment*.

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

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

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

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. *Hospice* care may be provided in the home or at a *hospice* facility where medical, social and psychological services are given to help treat patients with a terminal *illness*. *Hospice* services include routine home care, continuous home care, *inpatient hospice* and *inpatient* respite.

The list of *covered services* include:

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

For each day the *member* is confined in a *hospice*, benefits for room and board will not exceed the most common semi-private room rate of the *hospital* or nursing home with which the *hospice* is associated.

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

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

1. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice* care program;
2. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision; or
3. No benefits will be payable for charges related to *respite care*.

Hospital Benefits

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

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

Emergency Services

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

Note: *Some providers* that provide *emergency services* may not be in your network. These services are subject to *balance billing protections* and the *non-network provider* may not *balance bill* you for the difference between our *allowed amount* and their *billed amount*.

Long-Term Acute Care (LTACH)

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

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

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

b. Common conditions include metabolic disorders, stroke, heart failure, renal insufficiency, necrotizing pancreatitis, emphysema (COPD), peripheral vascular disease, and malignant/end-stage disease

4. Rehabilitation:
    a. Care needs cannot be met in a *rehabilitation* or *skilled nursing facility*
    b. Patient has a comorbidity requiring acute care
    c. Patient is able to participate in a goal-oriented *rehabilitation* plan of care
    d. Common conditions include CNS conditions with functional limitations, debilitation, amputation, cardiac disease, orthopedic *surgery*
5. Mechanical ventilator support:
    a. Failed weaning attempts at an acute care facility
    b. Patient has received mechanical ventilation for 21 consecutive days for six hours or more per day
    c. Ventilator management required at least every four hours as well as appropriate diagnostic services and assessments
    d. Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions
    e. Patient is hemodynamically stable and not dependent on vasopressors
    f. Respiratory status is stable with maximum PEEP requirement 10 cm H2O, and FiO2 60 percent or less with O2 saturation at least 90 percent
    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.

Mammography

Covered services for routine screenings for breast cancer shall include screenings at the following intervals: one screening mammogram for high-risk persons ages 35-39; one screening mammogram every two years, or annually, for all persons ages 40 through 49; and one mammogram per year for all persons 50 years of age and over. In addition, coverage for diagnostic mammography will be provided to any *member*, regardless of age, who has been diagnosed with breast cancer, when such services are referred by a *medical practitioner* acting within the scope of the practitioner's license.

Maternity Care

Coverage for outpatient and *inpatient* pre- and post-partum care including examinations, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and *hospital* stays for delivery or other *medically necessary* reasons (less any applicable *deductible amounts*, *copayment amounts* or *coinsurance amounts*). An *inpatient* stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a cesarean delivery. An *inpatient* stay longer than 48 hours for a vaginal

delivery or 96 hours for a cesarean delivery will require notification to us. We do not require that a *physician* or other health care provider obtain *prior authorization* for delivery. Other maternity benefits include *complications of pregnancy,* parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests. Coverage will only be provided for maternity services or care of the newborn child when such services have been *authorized* by your *network* health care provider.

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

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

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

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

Note: This provision does not amend the contract to restrict any terms, limits or conditions that may otherwise apply to *surrogates* and children born from *surrogates*. Please reference GENERAL NON-COVERED SERVICES AND EXCLUSIONS section, as limitations may exist.

Duty to Cooperate

We do not cover services or supplies related to a *member's pregnancy* when a *member* is acting as a *surrogate* and has entered into a *surrogacy arrangemen*t. For more information on excluded services, please see the GENERAL NON-COVERED SERVICES AND EXCLUSIONS section. *Members* who are a *surrogate* at the time of enrollment or *members* who agree to a *surrogacy arrangement* during the plan year must, within 30 calendar days of enrollment or agreement to participate in a *surrogacy arrangement*, send us written notice of the *surrogacy arrangement* to AmbetterHealthofDelaware.com at Member Services, 750 Prides Crossing, Suite 200, Newark, DE 19713. 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 *policy*, plus interest, attorneys' fees, costs and all other remedies available to us.

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* (*deductible amount*, *copayment amount, coinsurance amount* and *maximum out-of-pocket amount*), as listed in the *Schedule of Benefits*. Please refer to the DEPENDENT

MEMBER COVERAGE section of this document for details regarding coverage for a newborn child/coverage for an adopted child.

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

Medical and Surgical Expense Benefits

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

1. For *surgery* in a *physician's* office, an *inpatient* facility, an outpatient facility or a surgical facility, including services and supplies.
2. For 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 physician*, including consultations and *surgery* related services.
4. For chemotherapy (including oral chemotherapy), inhalation therapy, infusion therapy and radiation therapy or treatment in a *hospital* or office setting.
5. For *durable medical equipment*, *prosthetic devices*, *orthotic devices* or other *necessary medical supplies* following a medical or *surgical procedure* such as crutches, orthopedic splints, braces or casts. Please see the Durable Medical Equipment provision of this *policy.*
6. 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 if not replaced by or for you.
7. For the cost and the administration of anesthesia, oxygen, drugs, medications and biologicals.
8. For *medically necessary* reconstructive or cosmetic *surgery* including, but not limited to:
    a. reconstructive breast *surgery* charges as a result of a partial or total mastectomy. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedema.
    b. *reconstructive surgery* for craniofacial abnormalities

9. 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.
10. For infertility counseling and planning services when provided by a *network provider* and testing to diagnose infertility.
11. 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.
12. For routine patient care for *members* enrolled in an eligible cancer clinical trial that is deemed an *experimental or investigational* treatment if the services provided are otherwise considered *covered services* under this *policy*. See the **Clinical Trial Coverage** provision of this *policy*.
13. For the following types of tissue transplants:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.
    e. Implantable prosthetic lenses, in connection with cataracts.
    f. Skin grafts.
14. For X-rays, Magnetic Resonance Imaging (MRI), Computed Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT) and other diagnostic services. See **Radiology, Imaging and Other Diagnostic Testing** provision of this *policy*.
15. For *medically necessary telehealth services. Telehealth services* not provided through *Virtual 24/7 care* would be subject to the same *cost sharing* as the same health care services when delivered to a *member* in person.

16. For *surgery* or services related to cochlear implants and bone-anchored hearing aids.
17. For *medically necessary* services for complications arising from medical and surgical conditions.
18. For respiratory, pulmonary, cardiac, physical, occupational and speech therapy services. Please see **Habilitation, Rehabilitation and Extended Care Facility Expense Benefits** provision of this *policy*.
19. 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.
20. For *medically necessary* nutritional counseling, *prior authorization* may be required.
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 utilizations 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. For *medically necessary* baseline lead poisoning screening or testing. Benefits will also be provided for lead poisoning screening, testing, diagnostic evaluations, screening and testing supplies and home-visits for children who are at high risk for lead poisoning under guidelines and criteria established by the Division of Public Health.
30. For pediatric autoimmune neuropsychiatric disorders - We cover services and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy.
31. For weight modification or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery* and bariatric *surgery*.
32. For elective sterilization procedures (e.g., vasectomies). **Note:** No *cost share* applies, except for HSA-compatible plans.

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

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

    If services are rendered by a *non-network provider*, payment shall be provided to the *non-network provider* at our reasonable and customary reimbursement rates for the same or similar services in the same geographical area. The *non-network provider* cannot *balance bill* you for costs beyond these reasonable and customary rates.
3. *Surgery*, excluding tooth extraction, to treat craniomandibular disorders or malocclusions.

Medical Foods Benefits

We cover medical foods and formulas for:

1. Outpatient total parenteral nutritional therapy.

2. Outpatient elemental formulas for malabsorption.
3. Dietary formula when *medically necessary* for the treatment of:
    a. Phenylketonuria (PKU); and
    b. Inborn errors of metabolism.

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

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

Benefits for low-protein food products are limited to treating the following diseases:
1. Phenylketonuria (PKU)
2. Maple Syrup Urine Disease (MSUD)
3. Methylmalonic Acidemia (MMA)
4. Isovaleric Acidemia (IVA)
5. Propionic Acidemia
6. Glutaric Acidemia
7. Urea Cycle Defects
8. Tyrosinemia

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

Medical Vision Services

Covered services include:
1. Vision screenings to diagnose and treat a suspected disease or *injury* of the eye.
2. Vision screenings to determine the presence of refractive error.

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

Mental Health and Substance Use Disorder Benefits

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

Our *behavioral health* and *substance use disorder* vendor oversees the delivery and oversight of covered *behavioral health* services for us. If you need *mental health disorder* or *substance use disorder* treatment, you may choose any provider participating in our *behavioral health* vendor's provider *network* and do not need a referral from your *PCP* in order to initiate treatment. You can search for *network behavioral health* providers by using our "Find a Doctor" tool at AmbetterHealthofDelaware.com or by calling Member Services. *Deductible amounts*, *copayment amounts* or *coinsurance amounts* and treatment limits for covered *mental health disorder* and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

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

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

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

Inpatient

1. *Inpatient* detoxification treatment.
2. Crisis *stabilization*.
3. *Inpatient rehabilitation*.
4. *Residential treatment facility* for *mental health disorders* and *substance use disorders*.
5. *Inpatient* psychiatric hospitalization.
6. Electroconvulsive therapy (ECT).

Outpatient

1. Individual and group therapy for *mental health disorders* and *substance use disorders*.
2. Medication assisted treatment - combines *behavioral health* therapy and medications to treat *substance use disorders*.
3. Medication management services.
4. Outpatient detoxification programs.
5. Psychological and neuropsychological testing and assessment.
6. Evaluation and assessment for *mental health disorders* and *substance use disorders*.
7. *Applied behavior analysis*.
8. Telemedicine (individual/family therapy; medication monitoring; assessment and evaluation).
9. Partial hospitalization program (PHP).
10. Intensive outpatient program (IOP).
11. Mental health day treatment.
12. Electroconvulsive therapy (ECT).

13. *Transcranial magnetic stimulation (TMS).*
14. Annual *behavioral health* wellness check.

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

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

Outpatient Medical Supplies Expense Benefits

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

1. For artificial eyes or larynx, breast prosthesis or basic artificial limbs, including *medically necessary* repairs or replacement to restore or maintain a *member's* ability to perform activities of daily living or essential job-related activities.
2. For *medically necessary* foot orthotics, *prior authorization* may be required.
3. For four mastectomy bras per year if the *member* has undergone a covered mastectomy.
4. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion and a ventilator.
5. For the rental of one Continuous Passive Motion (CPM) machine per *member* following a covered joint *surgery*.
6. For one pair of eyeglasses or contact lenses per *member* following a covered cataract *surgery*.

Ovarian Cancer Monitoring and Screening Tests

Benefits are provided for monitoring tests for ovarian cancer subsequent to treatment and annual screening tests for women at risk for ovarian cancer. Such monitoring and screening tests include tests and examinations for ovarian cancer using any of the following methods that are recommended by a patient's *physician*:

1. Tumor marker tests supported by national clinical guidelines, national standards of care or peer reviewed medical literature.
2. Transvaginal ultrasound.
3. Pelvic examination.
4. Other screening tests supported by national clinical guidelines, national standards of care or peer reviewed medical literature.

"At risk for ovarian cancer" means:

1. Having a family history of any of the following:
    a. One or more first- or second-degree relatives with ovarian cancer.
    b. Cluster of women relatives with breast cancer.
    c. Nonpolyposis colorectal cancer.
    d. Breast cancer in a male relative.
2. Testing positive for any of the following genetic mutations
    a. BRAC1 or BRAC2.
    b. Lynch syndrome.
3. Having a personal history of any of the following:
    a. Ovarian cancer.
    b. Endometriosis.

c. Unexplained infertility.
d. Uterine fibroids.
e. Polycystic ovarian syndrome.

Pediatric Routine Vision Benefits – Children under the age of 19

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

1. Routine ophthalmological examination
    a. Refraction
    b. Dilation
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 evaluations/aids.

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

Services not covered:

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

Prescription Drug Expense Benefits

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

Covered services in this benefit subsection are limited to charges from a licensed pharmacy for:

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

As used in this section, *Standard Reference Compendia* means:

1. The American Hospital Formulary Service Drug Information;
2. The American Medical Association Drug Evaluation; or
3. The United States Pharmacopoeia-Drug Information.

Such *covered services* shall include those for prescribed, orally administered anti-cancer medications. The *covered services* shall be no less favorable than for intravenously administered or injected cancer medications that are covered as medical benefits under this *policy*.

Formulary or Prescription Drug List

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

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 Formulary or Prescription Drug List or for more information about our pharmacy program, visit AmbetterHealthofDelaware.com (under “For Member”, “Drug Coverage”) or call Member Services.

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

How to Fill a Prescription
Prescription 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 AmbetterHealthofDelaware.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 order* and your *member* identification card.

We also offer a three-month (90-day) supply of maintenance medications by mail or from *network* retail pharmacies for specific benefit plans. These drugs treat long-term conditions or *illnesses*, such as high blood pressure, asthma and diabetes. You can find a list of covered medications on AmbetterHealthofDelaware.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 amount*/*coinsurance amount*. 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 *network* mail order pharmacies and next steps for enrollment.

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

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

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

Split Fill Dispensing Program
Members are limited to 15-day supplies for the first 90 calendar 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 calendar days, *members* will fill their medications for 30-day supplies.

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

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

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

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

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

Non-Covered Services and Exclusions:
No benefits will be paid under this benefit provision for services provided or expenses incurred:

1. For *prescription drug* treatment of erectile dysfunction or any enhancement of sexual performance, unless such treatment is listed on the formulary.
2. For weight loss *prescription drugs,* unless otherwise listed on the formulary.
3. For immunization agents, 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 *experimental or investigational* drugs.
10. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program.
11. For more than a 30-day supply when dispensed in any one prescription or refill, or for some maintenance drugs, up to 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply network. Specialty drugs and other select drug categories are limited to 30-day supply when dispensed by retail or mail order. **Note:** Only the 90-day supply may be subject to the discounted *cost sharing* amount. Please consult your benefit information for further details.
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. For Foreign prescription medications, except those associated with an emergency medical condition while you are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this document if obtained in the United States.
14. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventive treatment is related to *member’s* vacation during out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
15. For medications used for cosmetic purposes.
16. For infertility drugs, unless otherwise listed on the formulary.
17. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
18. For drugs or dosage amounts determined by Ambetter’s Pharmacy and Therapeutics Committee to be ineffective, unproven or unsafe for the indication for which they have been prescribed, regardless of whether such drugs or dosage amounts have been approved by any governmental regulatory body for that use.
19. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner’s office.
20. For any drug dispensed from a non-lock-in pharmacy while *member* is in a lock-in program.

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

Preventive Care Expense Benefits

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

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

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

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

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

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

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

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

Prostate Specific Antigen Testing

Covered services include an annual digital rectal examination and prostate specific antigen tests performed to determine the level of prostate specific antigen in the blood for a *member* who is average-risk and at least 50 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 (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT,) mammogram, ultrasound). *Prior authorization* may be required, see *your Schedule of Benefits* for details. **Note:** Depending on the service performed, two bills may be incurred – both subject to any applicable *cost sharing* – one for the technical component (the procedure itself) and another for the professional component (the reading/interpretation of the results by a *physician* or other qualified practitioner).

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

Second Medical Opinion

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

1. Whenever a minor *surgical procedure* is recommended to confirm the need for the procedure.
2. Whenever a serious *illness* or *injury* exists.
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*.

Sleep Studies

Sleep studies are covered when determined to be *medically necessary*; *prior authorization* may be required.

Note: A sleep study can be performed either at home or in a facility.

Transplant Benefits

Covered services for transplant service expenses:

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

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

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

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

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

These medical expenses are covered to the extent that the benefits remain and are available under the *member's policy*, after benefits for the *member's* own expenses have been paid. In the event of

such coverage, the otherwise existing coverage of a live donor shall be secondary to benefits under the *member's policy*.

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

1. We will pay for the following services when the *member* is required to travel more than 60 miles from their *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 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 respective 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 the 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 costs directly related for transportation, lodging and any of the approved items listed in the *member* transplant reimbursement guidelines. However, you must make the arrangements and provide the necessary paid receipts for reimbursement within six months of the date of service in order to be reimbursed.
    e. Please refer to the *member* resources page for *member* reimbursement transplant travel forms and information at AmbetterHealthofDelaware.com.

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

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

8. The acquisition cost for the organ or bone marrow, when provided at an unauthorized facility or not obtained through the *Center of Excellence*.
9. For any transplant services and/or travel related expenses for *member* and donor, when preformed outside of the United States.
10. The following ancillary items listed below, will not be subject to *member* reimbursement under this *policy*:
    a. Alcohol/tobacco.
    b. Car, 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 violations tickets or parking tickets.
    j. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.).
    k. 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) is 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 *policy* 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

Urgent care services include *medically necessary* services by *network providers* and services provided at a *network 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 a *network urgent care center*.

Members are encouraged to contact their *primary care physician* for an appointment before seeking care from another provider, but *network urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *primary care physician* is not available and the condition

persists, call the 24/7 Nurse Advice Line, at 1-833-919-3214 (Relay 711). The 24/7 Nurse Advice Line is available 24 hours a day, seven days a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

WELLNESS PROGRAMS AND OTHER OFFERINGS

In connection with this *policy*, 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 *policy* 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 AmbetterHealthofDelaware.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 *policy*, 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 *deductible amounts*, *copayment amounts*, and *coinsurance amounts* 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.

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

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

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

1. Administered or ordered by a *physician*; and
2. *Medically necessary* to the diagnosis or treatment of an *illness* or *injury* or covered under the **Preventive Care Expense Benefits** provision in the MAJOR MEDICAL EXPENSE BENEFITS section of this *policy*.

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*.
2. For any portion of the charges that are in excess of the *eligible expense.*
3. For weight loss programs, gym memberships, exercise equipment or meal preparation programs.
4. For the reversal of sterilization and the reversal of vasectomies.
5. For non-therapeutic or illegal abortion.
6. For treatment of malocclusions disorders of the temporomandibular joint or craniomandibular disorders, except as described under the **Medical and Surgical Expense Benefits** provision in the MAJOR MEDICAL EXPENSE BENEFITS section of this *policy*.
7. For expenses for television, telephone or expenses for other persons.
8. For marriage, family or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions.
9. For telephone consultations between providers or for failure to keep a scheduled appointment.
10. For stand-by availability of a *medical practitioner* when no treatment is rendered.
11. For *dental service* expenses*,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under **Medical and Surgical Expense Benefits** provision under the MAJOR MEDICAL EXPENSE BENEFITS section of this *policy*.
12. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect.

13. Mental health services are excluded for:
    a. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities.
    b. Pre-marital counseling.
    c. Court ordered care or testing or required as a condition of parole or probation. Benefits will be allowed for services that are *medically necessary* and would otherwise be covered under this *policy*.
    d. Testing of aptitude, ability, intelligence or interest.
    e. Evaluation for the purpose of maintaining employment.
14. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the **Transplant Benefits** provision in THE MAJOR MEDICAL EXPENSE BENEFITS section of this *policy*.
15. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
16. While confined primarily to receive *rehabilitation, custodial care,* educational care or nursing services (unless expressly provided for in this *policy)*.
17. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy or occupational therapy, except as expressly provided for in this *policy*.
18. For eyeglasses, contact lenses, eye refraction, visual therapy or for any examination or fitting related to these devices, except as expressly provided for in this *policy*.
19. For hearing aids and supplies (e.g., batteries, cords or assisted learning devices), except as expressly provided for in this *policy*.
20. 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.
21. As a result of an *illness* or *injury* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's* workers' compensation claim, this exclusion will still apply unless that denial is *appealed* to the proper governmental agency and the denial is upheld by that agency.
22. For fetal reduction *surgery*.
23. Except as specifically identified as a *covered service* under this *policy*, services or expenses for alternative treatments, including acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
24. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); racing or speed testing any non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).

25. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
26. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
27. For the following miscellaneous items: artificial insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-covered services; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the **Medical Foods Benefits** provision in the MAJOR MEDICAL EXPENSE BENEFITS section of this *policy*; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits, unless required by *applicable law*; care or services provided to a non-member biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *rehabilitation* services for the enhancement of job, athletic, or recreational performance; routine or elective care outside the *service area*; treatment of spider veins; transportation expenses, unless specifically described in this *policy*.
28. Diagnostic testing, laboratory procedures screenings or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
29. For court ordered testing or care, unless *medically necessary*.
30. For a *member's illness* or *injury* which 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.*
31. *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*.

    Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except where the child is the adoptive child of insureds possessing an active *policy* with us and/or the child possesses an active *policy* with us at the time of birth.
32. For any medicinal and recreational use of cannabis or marijuana.
33. For expenses for services related to dry needling.

34. For expenses, services and treatments from a Naprapathic *specialist physician* for conditions caused by contracted, injured spasmed, bruised and/or otherwise affected myofascial or connective tissue.
35. For expenses, services, and treatments related to private duty nursing in an *inpatient* location.
36. Vehicle installations or modifications which may include adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.
37. For Assertive Community Treatment.
38. For expenses, services, and treatments from a Naturopathic specialists for treatment of prevention, self-healing and use of natural therapies.

TERMINATION

Termination of Policy

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

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

Refund upon Cancellation

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

Reinstatement

We will reinstate a *policy* when it is erroneously terminated or cancelled. The reinstatement will result in restoration of the enrollment with no break in coverage. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 calendar days prior to the date of reinstatement.

If you enrolled through the Exchange and your benefits were terminated because you did not pay your premium in full by the end of your grace period, you will not be able to reinstate your benefits. If you did not enroll through the Exchange and if any renewal premium is not paid within the time granted for payment, a subsequent acceptance by us or by any agent duly authorized by us to accept such premium, without requiring an application for reinstatement, shall reinstate benefits under this *policy*: provided, however, that if we or our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, benefits under the *policy* will be reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of such conditional receipt unless we have previously notified you in writing of disapproval of such application. The reinstated *policy* shall cover only *loss* resulting from such accidental *injury* as may be sustained after the date of reinstatement and *loss* due to such sickness as may begin more than 10 calendar days after such date. In all other respects, you and we shall have the same rights thereunder as they had under the *policy* immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which

premium has not been previously paid, but not to any period more than 60 calendar days prior to the date of reinstatement.

Discontinuance

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

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

RIGHT OF REIMBURSEMENT

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

If this plan provides benefits under this *policy* to a *member* for expenses incurred due to *third party injuries*, then we retain the right to repayment of the full cost of all benefits provided by this plan on behalf of the *member* that are associated with the *third party injuries*. Our rights of recovery apply to any recoveries made by or on behalf of the *member* from any sources, including but not limited to:

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

By accepting benefits under this *policy*, the *member* specifically acknowledges our right of recovery. When this *policy* provides health care benefits for expenses incurred due to *third party injuries*, we shall be included in the *member's* rights of recovery against any party to the extent of the full cost of all benefits provided by this *policy*. We may proceed against any party with or without the *member's* consent.

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

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

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

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

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

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

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

COORDINATION OF BENEFITS

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

It is a contractual provision of a majority of health benefit policies. We comply with federal and state regulations for COB and follows COB guidelines published by National Association of Insurance Commissioners (NAIC).

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

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

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

The term "plan" includes:

1. Group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group HMO insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.
2. Plan includes medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
3. Plan includes *hospital*, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid.
4. Plan does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
5. Plan does not include Individual or Family: Insurance contracts, direct payment subscriber contracts, coverage through health maintenance organizations (HMO's) or coverage under other prepayment, group practice and individual practice plans.
6. Plan whose benefits are by law excess to any private benefits coverage.

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

1. The plan has no order of benefits rules or its rules differ from those required by regulation; or
2. All plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary

plan (for example, two plans which have no order of benefit determination rules).

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

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. A plan may consider benefits paid or provided by another plan in determining its benefits only when it is secondary to that *other plan*.
2. If the *other plan* does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:
    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the policyholder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a *member* may continue to be excess to such basic benefits.

The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

1. If the person receiving benefits is the *member* and is only covered as an *eligible dependent member* under the *other plan*, this *policy* will be primary.
2. Subject to State Statues: Social Security Act of 1965, as amended makes Medicare secondary to the plan covering the person as a *dependent member* of an active employee, the order of benefit determination is:
    a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
    b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the *other plan* does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the *other plan* will determine which plan is primary.
3. If a child is covered by both parents’ plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child’s health care expenses:
    a. The plan of the parent who has custody will be primary.
    b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent’s plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
    c. If a court decree between the parents says which parent is responsible for the child’s health care expenses, then that parent’s plan will be primary if that plan has actual knowledge of the decree.

4. If the person receiving services is covered under one plan as an active employee or *member* (i.e., not laid-off or retired), or as the *spouse* or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the *spouse* or child of such a laid-off or retired employee, the plan that covers such person as an active employee or *spouse* or child of an active employee will be primary. If the *other plan* does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
5. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

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

Right to Receive and Release Needed Information

Certain facts about heath care coverage and services are needed to apply these COB rules and to determine benefits payable under this *policy* 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 *policy* and *other plans* covering the person claiming benefits. We need not tell or get the consent of any person to do this.

CLAIMS

Notice of Claim and Claim Forms

We must receive written notice of claim within 20 calendar days of the date the *loss* began or as soon as reasonably possible in order for benefits to be paid. Upon receipt of notice of claim, we will provide you with the *proof of loss* forms within 15 calendar days. In addition, claim forms to submit *proof of loss* are available at AmbetterHealthofDelaware.com under "For Members," "Forms and Materials".

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 may happen if your provider is not contracted with us.

If you have paid for services we agreed to cover, you can request reimbursement for the amount you paid, less any *deductible amount*, *copayment amount* or *cost sharing* that is your financial responsibility.

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

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

Cooperation Provision

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

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

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

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

Time for Payment of Claims

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

If you are in the *hospital* when this *policy* non-renews or terminates for any reason except non-payment of premium, this *policy* shall continue coverage for that hospitalization at the same benefit level for a 10-day period from the date of termination.

Payment of Claims

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

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

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

Foreign Claims Incurred for Emergency Care

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

Claims incurred outside of the United States for emergency care and treatment of a *member* must be submitted in English or with an English translation, at the *member’s* expense, within 180 calendar days from the date of service. Foreign claims must also include the applicable medical records in

English or with an English translation, at the *member's* expense to show proper *proof of loss* and evidence of any payment(s) to the provider.

Foreign claims must be submitted with the Member Reimbursement Medical Claim Form, along with all requested documents as detailed on the claim form. All forms and *member* resources are available at AmbetterHealthofDelaware.com.

The amount of reimbursement will be based on the following:

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

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

Assignment

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

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

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

Medicaid Reimbursement

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

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

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

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

Custodial Parent

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

Upon request by the custodial parent, we will:

1. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions, and limitations of the *policy*.
2. Accept claim forms and requests for claim payment from the custodial parent.
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 and Autopsy

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

Time Limit on Certain Defenses

After two years from the date of issue of this *policy* no misstatements, except fraudulent misstatements, made by the applicant in the enrollment application for the *policy* shall be used to void the *policy* or to deny a claim for *loss* incurred or disability (as defined in the *policy*) commencing after the expiration of the two-year period.

Change of Beneficiary

Unless you make an irrevocable designation of beneficiary, you have the right to change your beneficiary at any time and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this *policy* or to any change of beneficiary or beneficiaries or to any other changes in this *policy*.

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.

APPEAL AND GRIEVANCE PROCEDURES

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

Call Member Services

Please contact Member Services if you have questions or concerns. We will attempt to answer your questions during initial contact, as most concerns can be resolved with one phone call.

Filing an Appeal

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

An eligible appellant is:

1. A claimant*;*
2. A person *authorized* to act on behalf of the claimant. If the claimant chooses to elect an authorized representative other than their healthcare provider, written consent is required;
3. Written *consent* is not required for an authorized representative that is already legally authorized to act on behalf of the claimant; such as parent of a minor, legal guardian, or power of attorney. However, if received, we will accept any written expression of *authorization* without requiring specific form, language, or format;
4. In the event the claimant is unable to give consent: a *spouse*, family *member*, or the treating *provider*; or
5. In the event of an *expedited appeal*: the person for whom the insured has verbally given *authorization* to represent the claimant.

You can file an *appeal* by filling out our online “Grievance and Appeals Form” found under Member Forms and Materials on the Ambetter Health of Delaware public website or sending a letter to:

Ambetter Health of Delaware
Attn: Appeals and Grievances Department
P.O. Box 10341
Van Nuys, CA 91410
Fax: 1-833-886-7956

You can also file an *appeal* via telephone by contacting Member Services. Verbal request must be followed up in writing.

You have the right to submit written comments, documents, records, and other information relating to the claim for benefits. *You* have the right to review the claim file and to present evidence and testimony as part of the internal review process. The *appeal* will be promptly investigated. Benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice

and an opportunity for advance review. We are required to provide continued coverage pending the outcome of an *appeal*.

Call *us* if *you* have any questions regarding the process or how to file an *appeal*. We will get an interpreter for you or TTY services are also available, if needed.

Processing Your Standard Appeal

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

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

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

A reviewer of the same or similar specialty will review the request and make a determination. This reviewer will not be completed by the individual involved in the original decision and who is not the subordinate of that individual. The individual will have the appropriate clinical expertise on the condition or disease in review.

You 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*.

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

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

review.

Expedited Appeal

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

You or your authorized representative have 180 calendar days to file an *appeal* from the date we issue the *adverse benefit determination*. You may request an expedited *appeal* by telephone or in writing. You can call Member Services to initiate your expedited *appeal* request or send a letter to:

Ambetter Health of Delaware
Attn: Appeals and Grievances Department
P.O. Box 10341
Van Nuys, CA 91410
Fax: 1-833-886-7956

We will make a decision about the request within 72 hours. We will make reasonable efforts to notify you or your authorized representative of the results by telephone and will send our written determination to you or your authorized representative and your provider within 48 hours of making our decision. Due to the 72-hour resolution timeframe, the standard requirements for notification and acknowledgement do not apply to *expedited appeals*.

You 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*.

Written Appeal Response

The *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 written decision to the appellant will include, as applicable:

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 *policy* 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 or investigational* treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *policy* 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 *policy*, 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 *policy*'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 *policy* 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.

External Review

You have four months to make a written request for an external review after receiving notice that an adverse decision has been made under our internal *appeal* process.

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 reviewer.

We will request an external review and assignment of an Independent Utilization Review Organization (IURO) from the Delaware Department of Insurance (DOI). The request will be sent by email to:

DELAWARE'S INDEPENDENT HEALTH CARE APPEALS PROGRAM
Subject line: Petition for IURO
IURO@delaware.gov

You may also request an external review by completing and following instructions on the "Insurer's Petition for External Review" form located on the Delaware Department of Insurance Independent Health Care Appeals Program (IHCAP) resource web page located at:
https://insurance.delaware.gov/divisions/consumerhp/ihcap/

A decision will be made within 72 hours of the receipt of an expedited request and within 45 calendar days of the receipt of a standard request.

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 appeal* 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 appeal*; and
    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 health care item or service for which the claimant received *emergency services*, but has not been discharged from a facility; and
3. Claimants may request an expedited external review at the same time the internal *expedited appeal* is requested and an IURO 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, health care setting, level of care or effectiveness of a *covered service*; or the determination that a treatment is *experimental* or *investigational*, as determined by an external reviewer;
2. A determination of whether *surprise billing protections* apply and the *member cost-sharing* that applies for services subject to *surprise billing protections*; or
3. *Rescissions* of coverage.

Standard External Review Process

1. Upon receipt of a request for an external *appeal*, we will transmit the *appeal* electronically to the DOI as soon as possible, but within no more than three business days.
2. Within five calendar days of receipt of a request for an external *appeal*, the DOI shall assign an approved, impartial IURO to review the final coverage decision and shall notify the plan.
3. The assigned IURO shall, within five calendar days of assignment, notify you or your authorized representative in writing by certified or registered mail that the *appeal* has been accepted for external review.
    a. The notice shall include details stating that you or your authorized representative may submit additional written information and supporting documentation that the IURO shall consider when conducting the external review.
    b. You or your authorized representative shall submit such written documentation to the IURO within seven calendar days following the date of receipt of the notice.
    c. Upon receipt of any information submitted by you or your authorized representative, the assigned IURO shall as soon as possible, but within no more than two business days, forward the information to the plan.

d. The IURO must accept additional documentation submitted by the plan in response to additional written information and supporting documentation from you or your authorized representative.

4. Within seven calendar days after the receipt of the external review acceptance notification, the plan shall provide to the assigned IURO the documents and any information considered in making the final coverage decision.

   If the plan fails to submit documentation and information or fails to participate within the time specified, the assigned IURO may terminate the external review and make a decision, with the approval of the DOI, to reverse the final coverage decision.
5. The external review may be terminated if the plan decides to reverse its final coverage decision and provide coverage or payment for the health care service that is the subject of the *appeal*.

   Immediately upon making the decision to reverse its final coverage decision, the plan shall notify you or your authorized representative, the assigned IURO, and the DOI in writing of its decision. The assigned IURO shall terminate the external review upon receipt of the written notice from the carrier.
6. Within 45 calendar days after the IURO's receipt of an *appeal*, the assigned IURO shall provide written notice of its decision to uphold or reverse the final coverage decision to you or your authorized representative, the plan, and the DOI. The notice shall include the following information:
   a. The qualifications of the members of the review panel;
   b. A general description of the reason for the request for external review;
   c. The date the IURO received the assignment from the DOI to conduct the external review;
   d. The date(s) the external review was conducted;
   e. The date of its decision;
   f. The principal reason(s) for its decision; and
   g. References to the evidence or documentation, including practice guidelines and clinical review criteria, considered in reaching its decision.
7. The decision of the IURO is binding upon the carrier.

   The plan shall have the ability to appeal the issue to Superior Court.

Expedited External Review Process

1. You or your authorized representative may request an expedited *appeal* at the time the plan issues its final coverage decision if you suffer from a condition that poses an imminent, emergent or serious threat or has an emergency medical condition.

   For an emergency medical condition, you may file for an external review without having already exhausted the internal *appeal* process. To the extent the State process requires exhaustion of an internal claims and *appeals* process, exhaustion must be unnecessary where the plan has waived the requirement, the plan is considered to have exhausted the internal claims and *appeals* process under applicable law (including by failing to comply with any of the requirements for the internal *appeal* process), or you have applied for expedited external review at the same time as applying for an expedited internal *appeal*.

2. At the time the plan receives a request for an expedited *appeal*, the carrier shall immediately transmit the *appeal* electronically to the DOI, but within no more than three business days.
3. If the DOI determines that the review meets the criteria for expedited review, the DOI shall assign an approved, impartial IURO to conduct the external review and shall notify the plan.
4. At the time the plan receives the notification of the assigned IURO, the plan shall provide or transmit all necessary documents and information considered in making its final coverage decision to the assigned IURO electronically, by telephone, by facsimile or any other available expeditious method.
5. As expeditiously as your medical condition permits or circumstances require, but in no event more than 72 hours after the IURO's receipt of the expedited *appeal*, the IURO shall make a decision to uphold or reverse the final coverage decision and immediately notify you or your authorized representative, the plan, and the DOI of the decision.
6. Within one calendar day of the immediate notification, the assigned IURO shall provide written confirmation of its decision to you or your authorized representative, the plan, and the DOI.
7. The decision of the IURO is binding upon the carrier.

   The plan shall have the ability to appeal the issue to Superior Court.

Contacting the State Department of Insurance

The Insurance Commissioner's Office has two main locations. Phone calls are accepted from :00 a.m. to 4:30 p.m. and documents can be dropped off between Monday-Friday 8:30 a.m. to 3:30 p.m. ***Not sure who to call?*** **Dial (302) 674-7300 for the receptionist and you will be directed to the staff member who can best assist you.**

1351 West North Street
Suite 101
Dover, DE 19904
(302) 674-7300

1007 Orange Street, Suite 1010
Wilmington, DE 19801
(302) 577-5280

Filing a Grievance

A *grievance* is an expression of dissatisfaction about anything other than an *adverse benefit determination*. The *grievance* procedure allows the claimant an opportunity to resolve any issues and *complaints*. You or your authorized representative may file a *grievance*. The process is voluntary and is available for review of the contract, quality of care or quality of service issues that affect the claimant. The *grievance* process does not apply to *grievances* based solely on the basis that the contract does not cover the service or benefit limits for the health care service in question, provided that the exclusion of the specific service requested is clearly stated in the contract.

Grievances may refer to any dissatisfaction about:

1. Us, as the insurer; e.g., customer service *grievances* - "the person to whom I spoke on the phone was rude to me";
2. Providers with whom we have a direct or indirect contract;

   a. Lack of availability and/or accessibility of *network providers* not tied to an unresolved benefit denial; and
   b. Quality of care/quality of service issues;
3. Expressions of dissatisfaction regarding quality of care/quality of service;

You or your authorized representative may file a *grievance* by calling Member Services or in writing by mailing the *grievance* details to:

Ambetter Health of Delaware
Attn: Grievances and Appeals Department
P.O. Box 10341
Van Nuys, CA 91410

An eligible grievant is:
1. A claimant;
2. Person authorized to act on behalf of the claimant. If the claimant chooses to elect an authorized representative, written consent is required;
3. Written *consent* is not required for an authorized representative that is already legally authorized to act on behalf of the claimant; such as parent of a minor, legal guardian, or power of attorney. However, if received, we will accept any written expression of *authorization* without requiring specific form, language, or format; or
4. In the event the claimant is unable to give consent: a *spouse*, family member, or the treating provider.

Important: *Adverse benefit determinations* reviews are *appeals* and not *grievances* and will follow standard Patient Protection and Affordable Care Act (PPACA) internal *appeals* processes.

Processing Your Grievance

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

*Grievance*s will be promptly investigated and will be resolved within 45 calendar days of receipt. The time period may be extended for an additional 14 calendar days. We will provide you or your authorized representative, if applicable, written notification of the following within the first 45 calendar days:
1. That we have not resolved the *grievance*;
2. When our resolution of the *grievance* may be expected; and
3. The reason why the additional time is needed.

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

Complaints received from the State Department of Insurance

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

Appeals and Grievances Filing and Key Communication Timelines

Request Type	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard Grievance	N/A	5 Business Days	45 Calendar Days	14 Calendar Days
Standard Pre-Service Appeal	180 Calendar Days	5 Business Days	30 Calendar Days	14 Calendar Days
Expedited Pre-Service Appeal	180 Calendar Days	N/A	72 Hours	14 Calendar Days
Standard Post-Service Appeal	180 Calendar Days	5 Business Days	30 Calendar Days	14 Calendar Days
Standard External Review	4 months	10 Calendar Days	45 Calendar Days	N/A
Expedited External Review	4 months	N/A	72 Hours	N/A

GENERAL PROVISIONS

Entire Policy
This *policy,* with the enrollment application, the *Schedule of Benefits*, and any amendments and/or riders, is the entire *policy* between you and us. No agent may:

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

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

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

1. The misrepresented fact is contained in a written application, including amendments, signed by a *member*.
2. A copy of the enrollment application and any amendments has been furnished to the *member(s)* or to their beneficiary.
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 *policy*, if a *member* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *policy* or in filing a claim for *policy* benefits, we have the right to demand that *member* pay back to us all benefits that we provided or paid during the time the *member* was covered under the *policy*.

Conformity with Applicable Laws
Any part of this *policy* in conflict with *applicable laws* on this *policy's effective date* or on any premium due date is changed to conform to the minimum requirements of *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 AmbetterHealthofDelaware.com or call Member Services.

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

Language

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

English:	If you, or someone you are helping, have questions about Ambetter Health of Delaware, 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 1-833-919-3214 (TTY 711).
Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter Health of Delaware 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 1-833-919-3214 (TTY 711).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter Health of Delaware 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 1-833-919-3214 (TTY 711)。
Frenche Creole:	Si ou menm, oswa yon moun w ap ede, gen kesyon sou Ambetter Health of Delaware, epi nou pa mètrize Anglè, nou gen dwa pou jwenn èd ak enfòmasyon nan lang nou gratis epi nan moman ki apwopriye a. Si ou menm, oswa yon moun w ap ede, gen yon pwoblèm pou tande ak/oswa yon pwoblèm pou wè ki pètibe kominikasyon nou, nou gen dwa pou resevwa asistans ak sèvis oksilyè gratis epi nan moman ki apwopriye a. Pou resevwa sèvis tradiksyon oswa sèvis oksilyè yo, tanpri kontakte Sèvis Manm yo nan 1-833-919-3214 (TTY 711).
Gujarati:	જો તમને અથવા તમે જેમની મદદ કરી રહ્યા હો એવી કોઈ વ્યક્તિને Ambetter Health of Delaware 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 1-833-919-3214 (TTY 711) પર સભ્યની સેવાઓનો સંપર્ક કરો.
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter Health of Delaware 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 1-833-919-3214 (TTY 711).
Korean:	귀하 또는 귀하의 도움을 받는 분이 Ambetter Health of Delaware에 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 1-833-919-3214 (TTY 711)번으로 가입자 서비스부에 연락해주십시오.

Italian:	Se Lei o una persona a cui sta fornendo assistenza ha domande su Ambetter Health of Delaware 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 1-833-919-3214 (TTY 711).
Vietnamese:	Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter Health of Delaware 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 1-833-919-3214 (TTY 711).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter Health of Delaware 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 1-833-919-3214 (TTY 711).
Tagalog:	Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter Health of Delaware, 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 1-833-919-3214 (TTY 711).
Hindi:	अगर आप या कोई ऐसा व्यक्ति जिसकी आप सहायता कर रहे हैं, के पास Ambetter Health of Delaware 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 1-833-919-3214 (TTY 711) पर सदस्य सेवाएं से संपर्क करें.
Urdu:	اگر آپ، یا جس کی آپ مدد کر رہے ہیں وہ Ambetter Health of Delaware کے بارے میں سوالات کرنا چاہتے ہیں، اور وہ انگریزی میں ماہر نہیں ہیں، تو آپ کو اپنی زبان میں بلا معاوضہ اور بروقت مدد اور معلومات حاصل کرنے کا حق ہے۔ اگر آپ، یا جس کی آپ مدد کر رہے ہیں، انہیں سماعت اور/یا بصارت میں کوئی پریشانی درپیش ہے جس سے مواصلت میں رکاوٹ پیدا ہوتی ہے، تو آپ کو مفت اور بر وقت معاون امداد اور خدمات حاصل کرنے کا حق ہے۔ ترجمہ یا معاون خدمات حاصل کرنے کے لیے، براہ کرم 1-833-919-3214 (TTY 711) پر ممبر سروسز سے رابطہ کریں۔
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter Health of Delaware، ولم تكن بارعًا باللغة الإنكليزية، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت أنت أو أي شخص تساعده تعاني من حالة سمعية و/أو بصرية تعيق التواصل، فلديك الحق في تلقي مساعدات وخدمات إضافية من دون أي تكلفة وفي الوقت المناسب. لتلقي خدمات الترجمة أو خدمات إضافية، يرجى الاتصال بـ خدمات الأعضاء على 1-833-919-3214 (TTY 711).

Telugu:	మీకు లేదా మీరు సహాయం చేస్తున్న ఎవరికైనా Ambetter Health of Delaware గురించి ప్రశ్నలు ఉంటే అలాగే ఆంగ్లంలో ప్రావీణ్యం లేకుంటే, ఎటువంటి ఖర్చు లేకుండా, సకాలంలో సహాయం అలాగే సమాచారాన్ని మీ భాషలో పొందే హక్కు మీకు ఉంది. మీరు, లేదా మీరు సహాయం చేస్తున్న ఎవరైనా, కమ్యూనికేషన్‌కు ఆటంకం కలిగించే శ్రవణ మరియు/లేదా దృశ్యమాన స్థితిని కలిగి ఉంటే, ఎటువంటి ఖర్చు లేకుండా, సకాలంలో సహాయక సహాయాలు, సేవలను పొందే హక్కు మీకు ఉంటుంది. అనువాదం లేదా సహాయక సేవలను అందుకోవడానికి, దయచేసి 1-833-919-3214 (TTY 711) లో సభ్యుల సేవలును సంప్రదించండి.
Dutch:	Als u, of iemand die u helpt, vragen heeft over Ambetter Health of Delaware en de Engelse taal niet machtig is, hebt u het recht om kosteloos en tijdig hulp en informatie in uw taal te krijgen. Als u, of iemand die u helpt, een auditieve en/of visuele beperking heeft die de communicatie belemmert, hebt u recht om kosteloos en tijdig hulpmiddelen en ondersteuning te ontvangen. Om vertaal- of ondersteuningsdiensten te ontvangen, kunt u contact opnemen met Ledenservice via 1-833-919-3214 (TTY 711).