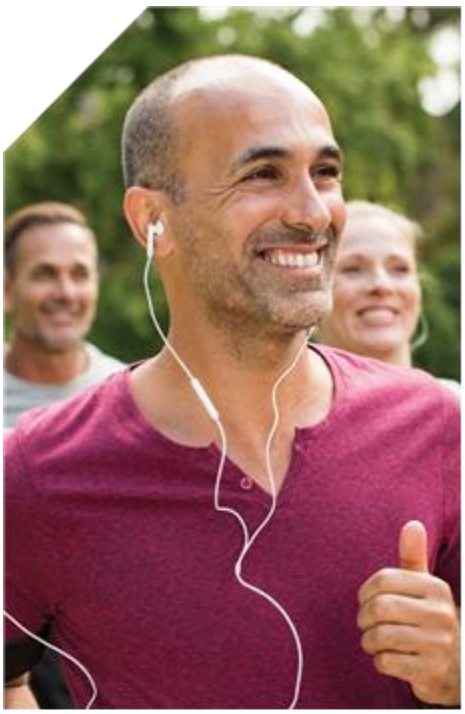
ambetter. FROM absolute total care



2025 EVIDENCE OF COVERAGE

Ambetter + Adult Vision + Adult Dental

79222SC002 - 2025

Ambetter.AbsoluteTotalCare.com

Ambetter from Absolute Total Care

Ambetter + Adult Vision + Adult Dental

Home Office: 100 Center Point Circle, Suite 100 Columbia, SC 29210

Major Medical Expense Insurance Policy

In this *policy,* the terms *"*you*"* or *"*your*"* will refer to the *member* or any *dependent members* enrolled in this *policy*. The terms *"*we*," "*our*,"* or *"*us*"* will refer to Absolute Total Care or Ambetter.

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

Annually, we must file this product, the cost share and the rates associated with it for approval. Guaranteed renewable means that your plan will be renewed into the subsequent year's approved product on the anniversary date unless terminated earlier in accordance with the policy terms. You may keep this policy (or the new policy you are mapped to for the following year) in effect by timely payment of the required premiums. In most cases you will be moved to a new policy each year, 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 a new policy at the same metal level with a similar type and level of benefits, to residents of the state where you then live; (2) we withdraw from the service area; or (3) there is fraud or an intentional material misrepresentation made by or with the knowledge of a member in filing a claim for covered services.

In addition to the above, this guarantee for continuity of coverage shall not prevent us from cancelling or non-renewing this policy in the following events: (1) non-payment of premium; (2) a member is found to be in material breach of this policy; or (3) a change in federal or state law no longer permits the continued offering of such coverage, such as Centers for Medicare and Medicaid Services ("CMS") guidance related to individuals who are Medicare eligible.

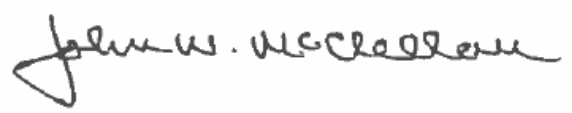
Annually, we may change the rate table used for this *policy* form. Each premium will be based on the rate table in effect on that premium's due date. The *policy* plan, and age of *members,* type and level of benefits, and place of *residence* on the premium due date are some of the factors used in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

At least 31 calendar days' notice of any plan to take an action or make a change permitted in accordance with this *policy* 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.

RIGHT TO RETURN POLICY

Please read your *policy* carefully. If you are not satisfied, please return this *policy* to our agent or us within 10 calendar days of receipt. However, if we provide you with this *policy* directly, you can return the *policy* within 30 calendar days from the date of receipt of the policy. All premiums paid will be refunded, less claims paid, and the *policy* will be considered null and void from the *effective date*.

Absolute Total Care



John McClellan
Health Plan President & CEO

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INTRODUCTION

Welcome to Ambetter from Absolute Total Care! This *policy* is a Health Maintenance Organization (**HMO**) from Ambetter from Absolute Total Care. We have prepared this *policy* to help explain your coverage. Please refer to this *policy* whenever you require medical services.
It describes:

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

This *policy*, the *Schedule of Benefits*, the 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.

Because many of the provisions are interrelated, you should read the entire *policy* to gain a full understanding of your coverage. Many words used in this *policy* have special meanings when used in a health care setting: 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 entire *policy* carefully.

How to Contact Us

Ambetter from Absolute Total Care
100 Center Point Circle
Suite 100,
Columbia, SC 29210

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

Member Services	**1-833-270-5443**
Relay	**711**
Fax	**1-833-719-7815**
Emergency	**911**
24/7 Nurse Advice Line	**1-833-270-5443**

Interpreter Services

Ambetter from Absolute Total Care has a free service to help our *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 languages other than English via phone. *Members* who are blind or visually impaired and need help with interpretation can call *Member* Services for an oral interpretation.

To arrange for interpretation services, call Member Services.

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, race, religion, gender, sexual orientation, national origin, physical or mental disability, expected health or genetic status, or *health status-related factors*.

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

You have the right to:

1. Participate with your *physician* and *medical practitioners* in decisions about your health care. This includes working on any treatment plans and making care decisions. You should know any possible risks, problems related to recovery, and the likelihood of success. You shall not have any treatment without consent freely given by you or your legally *authorized representative*. You will be informed of your care options.
2. Know who is approving and performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which you have coverage.
4. Be treated with respect and dignity.
5. Privacy of your personal health information, consistent with state and federal laws, and our policies.
6. Receive information or make recommendations, including changes, about our organization and services, our *network* of *physicians, medical practitioners*, *hospitals* and other facilities and your rights and responsibilities.
7. Candidly discuss with your *physician* and *medical practitioners* appropriate and *medically necessary* care for your condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *PCP* about what might be wrong (to the level known), treatment and any known likely results. Your *PCP physician* 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 and 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 providers(s) of the medical consequences. You are responsible for your actions if treatment is refused or if the *PCP's* instructions are not followed. You should discuss all concerns about treatment with your *PCP physician*. 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 provider* if you want more information about your treatment or would like to explore additional treatment options.
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 entire *policy*.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about your health that we or your medical

practitioners need in order to provide care. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your *physician* until you understand the care you are receiving.

4. Review and understand the information you receive about us. You need to know the proper use of *covered services*.
5. Show your *member* identification card and keep scheduled appointments with your *physician* and call the *physician's* office during office hours whenever possible if you have a delay or cancellation.
6. Know the name of your assigned *PCP*. You should establish a relationship with your *physician*. You may change your *PCP* verbally or in writing by contacting Member Services.
7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
8. Follow the treatment plans and instructions for care that you have agreed on with your health care professionals and *physician*.
9. Tell your health care professional and *physician* if you do not understand your treatment plan or what is expected of you. You should work with your *PCP* to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.
10. Follow all health benefit plan guidelines, provisions, policies, and procedures.
11. Use any emergency room only when you think you have a medical *emergency*. For all other care, you should call your *PCP*.
12. When you enroll in this coverage, give all information about any other medical coverage you have. If, at any time, you get other medical coverage besides this coverage, you must tell us.
13. Pay your monthly premiums *deductible 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 the following: birth of a child, adoption, marriage, divorce, change of address, adding/removing a dependent, spouse/domestic partner be-comes eligible under a different insurer or incarceration where *member* cost share would need to transfer from one *policy* to another *policy*.

IMPORTANT INFORMATION

Provider Directory

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

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 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.

If you provide documentation that you received incorrect information from us about a *provider's network* status prior to a visit, you will only be responsible for the network *cost sharing* amount and the network *deductible* or *maximum out-of-pocket* shall be applied.

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*. A temporary *member identification card* can be downloaded from Ambetter.AbsoluteTotalCare.com.

The *member* identification card will show your name, *member* identification number, and *copayment amounts* required at the time of service. Any applicable deductibles, and any applicable out-of-pocket maximum limitations will also be accessible through the member identification card. If you do not get your *member* identification card within a few weeks after you enroll, please call Member Services. We will send you another card.

Website

Our website can answer many of your frequently asked questions and has resources and features that make it easy to get quality care. Our website can be accessed at

Ambetter.AbsoluteTotalCare.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 preferred drug List.
8. *Deductible* and *copayment* accumulators.
9. Selecting a *PCP*.

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 *physicians* 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 the 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 receive a combination of therapies such as physical, occupational, and speech therapy as needed and are medically managed by specially trained physicians. *Rehabilitation* services must be performed for three or more hours per day, five to seven calendar days per week, while the covered person is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *skilled nursing facility*.

Advance premium tax credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Health Insurance Marketplace. *Advance premium tax credits* can be used right away to lower your monthly premium costs. If you qualify, you may choose how much *advance premium tax credit* to apply to your premiums each month, up to the 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*, *coinsurance*, and *copayment*) per the *member's* benefits. This amount excludes agreed to amounts between the *provider* and us as a result of federal or state arbitration.

NOTE: If you receive services from a *non-network provider*, you may be responsible for the difference between 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*. 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 *balance billed* in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.

Appeal means a request for a plan to reconsider a previous decision regarding an *adverse benefit determination*, including adverse medical necessity and benefit decisions. A *member* or *authorized representative* of a *member* may *appeal* any adverse decision. There may be several levels of *appeal* and the *appeal* process may be conducted internally, externally, or both as required by state/federal regulations.

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.

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

Applied behavior analysis therapy 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*.

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

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

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

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

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

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

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

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

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

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

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 1st through December 31st.

Care management means programs apply systems, science, incentives, and information to improve medical/behavioral health practice and assist *members* and their support system to become engaged in a collaborative process, designed to manage medical/social/mental health conditions more effectively.

Case Management means Ambetter adheres to the Case Management Society of America's (CMSA) definition of *case management*: "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and quality cost effective outcomes" and abide by the principles of *case management* practice, as described in CMSA's most recent version of the Standards of Practice for *Case Management*.

Center of Excellence means a *hospital* that:

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

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

Claimant means a covered person or his or her *authorized representative.*

Clinically urgent 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 a *clinically urgent grievance*.

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

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.

Complaint means any expression of dissatisfaction expressed to us by you, or a *claimant*'s *authorized representative*, about us or the *providers* with whom we have 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*.

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

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

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

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

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

Covered services means health care 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 covered person with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily *injury*.

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

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

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

Deductible or ***deductible amount*** means the amount that you must pay in a *calendar year* for *covered service expenses* before we will pay benefits (other than preventive health benefits as discussed under the Preventive Care Expense Health Provision). For family coverage, there is a family *deductible amount* which is two times the individual *deductible amount*. Both the individual and the family *deductible amounts* are shown in the *Schedule of Benefits*.

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

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

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

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

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

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

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

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

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

1. A natural child;
2. A legally adopted child;
3. A foster child placed in your custody;
4. A child placed with you for adoption prior to reaching age 18;
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 expense* as determined below.

1. For *network providers*: When a *covered service* is received from a *network provider*, the *eligible expense* is the contracted fee with that *provider*.
2. For *non-network providers*, unless otherwise required by federal or South Carolina law, the

eligible expense is as follows:

a. When *balance billing protections* apply to a *covered service* received from a *non-network provider*, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the *provider* as payment in full. If the *provider* has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by *applicable law*, the *eligible expense* is reimbursement as determined by us and as required by *applicable law*.

b. For all other *covered services* received from a *non-network provider* for which any needed *authorization* is received from us, the *eligible expense* is reimbursement as determined by us and as required by *applicable law*. In addition to applicable cost sharing, you may be *balanced billed* for these services.

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

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

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

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

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

Experimental or investigational means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, we determine to be 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 (HHS);
      ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
      iii. Not an *unproven service;* or
   d. It has FDA approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the FDA or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*
4. *Experimental* or *investigational* according to the *provider's* research protocols.

Items 3. and 4. above do not apply to phase 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 (ECF) means a primarily engaged facility that provides 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 pulmonary tuberculosis or *behavioral health*.

External appeal means a request for an independent, external review of the final adverse determination made by the Plan through its internal *appeal* process. This may include, but is not limited to, Independent Review Entity, Quality Improvement Organization, or State Fair Hearing.

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

If no credible scientific evidence is available, then standards 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 any dissatisfaction with us, as an insurer offering a health benefit plan or our administration of a health benefit plan that is expressed in writing in any form to us by, or on behalf of, a *claimant* including any of the following:

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

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

Health status-related factors means any of the following factors:

1. *Health status*;
2. Medical condition, including both physical and mental *illnesses* and behaviors related to *health status*;
3. Claims experience;
4. Receipt of health or *behavioral health* care;
5. Medical history;
6. Genetic information;
7. Evidence of insurability, including contributions arising out of acts of domestic violence; and
8. Disability.

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

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

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

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

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

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

Hospice means services designed for and provided to *members* who are 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.

Hospice care program means a coordinated, interdisciplinary program prescribed and supervised by a *physician* to meet the special physical, psychological, and social needs of a *terminally ill member* and those of his or her *immediate family.*

Hospital means an institution that:

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

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *skilled nursing 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*.

Infertility means the inability, after 12 consecutive months of unsuccessful attempts, to conceive a child despite regular exposure of female reproductive organs to viable sperm.

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

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

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

Maternity services mean prenatal care, perinatal care, and childbirth.

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 amount,* and *coinsurance* amounts all contribute towards the *maximum out-of-pocket amount.* Your individual and family *maximum out-of-pocket amounts* are shown in the *Schedule of Benefits*.

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

Medical practitioner means 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 our decision as to whether any medical service, items, supply, or treatment to diagnose or treat a *member's illness* or *injury*:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to *generally accepted standards of medical practice*;
3. Is not *custodial care*;
4. Demonstrate that the *member* is reasonably capable of improving in his/her functional ability;
5. Is not *experimental* or *investigational* treatment;
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 medical services, supplies, or treatment that are 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 means medical supplies that are:

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

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

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

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

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

Non-elective cesarean section means:

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

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

1. *Emergency services*, as described in the *covered services* 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*; or
3. Air ambulance services; and
4. Situations otherwise specifically described in this *policy*.

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

1. The *non-network provider* provides the *member* a written notice in the format required by *applicable law* that states the provider is a *non-network provider*, includes a good faith estimate of the *non-network provider's* charges for the services, identifies any *prior authorization* or other limitations that may be required in advance of receiving the services, and clearly states that consent is optional, and the *member* may seek care from a *network provider*.
2. The *non-network provider* provides the notice described above to the *member* at least 72

hours before the services are furnished, except that for services scheduled within 72 hours, the notice must be provided at least three hours before the services are furnished.

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

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

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

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

Other plan means any plan or *policy* that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, automobile no-fault or medical pay, homeowner insurance medical pay, premises medical pay, nonprofit health service plans, health maintenance organization subscriber *policy*, 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/Substance Use Disorder* services, refers to a mental health or *substance use disorder* provider licensed/certified by the state in which care is being rendered and performing services within the scope of that license/certification.

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

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

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

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

Post-service claim means any claim for benefits for medical care or treatment that 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 *inpatient* or *outpatient services* with respect to the visit in which other *emergency services* are furnished.

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

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

Pre-service appeal means a request to change an adverse determination for care or service that the plan must approve, in whole or in part, in advance of the *member* obtaining care or services.

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.

Primary care physician or ***PCP*** means a provider who gives or directs health care services for you. *PCP*s include internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), *Physician* Assistants (PA), obstetrician gynecologist (ob-gyn) and pediatricians or any other practice allowed by the *policy. A PCP* supervises, directs, and gives initial care and basic medical services to you and is in charge of your ongoing care.

Prior authorization means a decision to approve specialty or other *medically necessary* care for a *member* by the *member's PCP* or provider 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, and birth abnormalities, 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*. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment.

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

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

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

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

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

Rescission of a *policy* means a determination by us 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, skilled nursing facility,* or *rehabilitation facility;* or
2. Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

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

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

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

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

Skilled nursing facility means an institution, or a distinct part of an institution, that:

1. Is licensed as a *hospital*, *skilled nursing facility*, or *rehabilitation facility* by the state in which it operates;
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *physician* and the direct supervision of a registered nurse;
3. Maintains a daily record on each patient;

4. Has an effective *utilization review* plan;
5. Provides each patient with a planned program of observation prescribed by a *physician;* and
6. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing *generally accepted standards of medical practice* for that condition.

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

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

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

Spouse means the person to whom you are lawfully married.

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

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

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

Telehealth services means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment,

education, *care management*, and self-management of a patient's health care while the patient is at the originating site and the provider for telehealth is at a distant site. *Telehealth services* includes synchronous interactions and asynchronous store and forward transfers.

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*.

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

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.

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.

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

Tobacco or nicotine use, or ***use of tobacco or nicotine*** means *use of tobacco or nicotine* by individuals who use *or nicotine or tobacco* on average four or more times per week (or used *tobacco or nicotine* within 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 t*obacco*.

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 or stepchild*;
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;
6. The date a domestic partnership is established; or
7. We do not deny enrollment of a child under the health plan of the child's parent on the grounds that the child:
   a. Was born out of wedlock;
   b. Is not claimed as a dependent on the parent's federal tax return; or
   c. Does not reside with the parent or within our *service area*.

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. To provide additional coverage, you must contact the entity that you initially enrolled for coverage through (either the Health Insurance Marketplace or us) and add the *eligible child* as a dependent.

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

Coverage for an Adopted Child

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

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

Additional premium will be required to continue coverage beyond the 31st day following placement of the child. The required premium will be calculated from the date of placement for adoption. Coverage

of the child will terminate retroactively to the 31st day following placement unless we have received both:

a. Notification of the addition of the child from the Health Insurance Marketplace within 60 calendar days of the placement; and
b. Any additional premium required for the addition of the child within 90 calendar days of the date of placement.

As used in this provision, *"*placement*"* means the earlier of:

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

Adding Other Dependent Members

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

ONGOING ELIGIBILITY

For All Members

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

1. The *subscriber* residing outside the *service area* or moving permanently outside the *service area* of this plan;
2. The date of termination that the Health Insurance Marketplace provides us upon your request of cancellation to the Health Insurance Marketplace, or if you enrolled directly with us, the last day of the month we receive a request from you to terminate this contract, or any later date stated in your request will be effective the last day of the requested month but no further than 60 calendar days in advance;
3. 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*;
4. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or
5. The date of a *member's* death.

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

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 unless otherwise outlined below.

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

1. Incapable of self-sustaining employment by reason of intellectual disability or physical disability; and
2. Chiefly dependent upon the policyholder or subscriber for support and maintenance, so long as proof of the incapacity and dependency is furnished to us by the *member* within 31 calendar days of the child's attainment of the limiting age and subsequently as may be required by us but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Whether you are enrolled through the Health Insurance Marketplace and you have material modifications (examples include a change in life event such as marriage, death, or other change in family status), you can access your consumer dashboard at enroll.ambetterhealth.com to process these changes.

Upon reaching the limiting age, a former dependent *eligible child* may be issued a *policy* providing coverage which is most nearly similar to, but not greater than the coverage under which they were formerly covered, if they apply for such coverage within 30 calendar days following the attainment of the limiting age and pay all required premiums. Any probationary or waiting period must be considered met to the extent coverage was in force under this *policy*.

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 and Limited Enrollment

In general, a *qualified individual* has 60 calendar days to report certain life changes, known as "qualifying events," to the Health Insurance Marketplace or by using Ambetter's *Enhanced Direct Enrollment* tool. If a *qualified individual* loses Medicaid or CHIP coverage that is considered minimum essential coverage, they have up to 90 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* or becomes a *dependent* through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order.
    a. 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 calendar days during the 60 calendar days preceding the date of marriage;
3. A *qualified individual* or *dependent*, who was not previously a citizen, national, or lawfully present individual gains such status; or who is no longer incarcerated or whose incarceration is pending the disposition of charges;
4. A *qualified individual's* enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or its instrumentalities as evaluated and are determined by the Health Insurance Marketplace;
5. An enrollee or *dependent* adequately demonstrates to the Health Insurance Marketplace that the plan in which he or she is enrolled substantially violated a material provision of its *policy* in relation to the enrollee;
6. A *qualified individual*, enrollee, or *dependent*, adequately demonstrates to the Health Insurance Marketplace that a material error related to plan benefits, service area, or premium influenced the *qualified individual*'s or enrollee's decision to purchase the *QHP*;
7. An enrollee or *dependent* enrolled in the same plan is determined newly eligible or newly ineligible for *advance premium tax credits* or has a change in eligibility for *cost sharing reductions*;
8. A *qualified individual* or *dependent* who is enrolled in an eligible employer-sponsored plan is determined newly eligible for *advance premium tax credits* based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-2I (3);
9. A *qualified individual*, enrollee, or *dependent* gains access to new *QHP*s as a result of a permanent move, and had minimum essential coverage as described in 26 CFR 1.5000A–1(b) for one or more calendar days during the 60 calendar days preceding the date of the permanent move;
10. A *qualified individual* or *dependent* who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a plan, or change from one plan to another one time per month;

11. A *qualified individual* or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by Health and Human Services (HHS), that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide;
12. A *qualified individual*, enrollee, or *dependent* is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B–2, and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
13. A *qualified individual* or *dependent* is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 calendar days after the qualifying event; or applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;
14. A *qualified individual* newly gains access to an employer sponsored Individual Coverage Health Reimbursement Arrangement (ICHRA) (as defined in 45 CFR 146.123(b)) or a Qualified Small Employer Health Reimbursement Arrangement (QSHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code);
15. At the option of the Health Insurance Marketplace, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a plan through the Health Insurance Marketplace following termination of enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence;
16. A *qualified individual* or dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions or government subsidies completely cease; or
17. A *qualified individual* or *member*, or their *dependent member*, who is eligible for advance payments of the premium tax credit, and whose household income is expected to be no greater than 150 percent of the federal poverty level.

To determine if you are eligible and apply for a Special Enrollment Period, ***please visit Healthcare.gov and search for "special enrollment period."*** The Health Insurance Marketplace is responsible for all health care eligibility and enrollment decisions for *members* who enrolled via the Marketplace. If you are currently enrolled in Ambetter from Absolute Total Care, 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 date*s.

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

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

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

PREMIUMS

Premium Payment

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

Grace Period

When a *member* is receiving a premium subsidy:

After the first premium is paid, a grace period of 90 calendar days from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period.

We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. We will notify HHS of the non-payment of premiums, and will notify 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 his or her grace period as described above.

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

Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 60-day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *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, and will notify the *member*, as well as *providers* of the possibility of denied claims when the *member* is in the grace period.

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. During the time the *member* is uninsured, they will be responsible for paying any medical bills incurred.

Third Party Payment of Premiums or Cost Sharing

We require each *member* 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 your premiums on your behalf:

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

6. Private, not-for-profit foundations which have no incentive for financial gain and 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* through the remainder of the *calendar year*.

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

Prior Coverage

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

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

Misstatement of Age

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

Change or Misstatement of Residence

If you change your *residence*, you must notify the Health Insurance Marketplace or log into your Ambetter *member* portal to process your change via Ambetter's *Enhanced Direct Enrollment* tool, of your new *residence* within 60 calendar days of the change. As a result, your premium may change, and you may be eligible for a special enrollment period. See the Special and Limited Enrollment provision for more information.

Misstatement of Tobacco or Nicotine Use

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

PRIOR AUTHORIZATION

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

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

Prior Authorization Required

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

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

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

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

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

1. At least five calendar days prior to an elective admission as an *inpatient* in a *hospital*, extended care or *rehabilitation facility*, *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 any inpatient admission.
5. At least five calendar days prior to the start of *home health care* except those *members* needing *home health care* after *hospital* discharge.

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

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

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

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

required to comply with certain procedures, including obtaining *prior authorization* for certain services, following a pre-approved treatment plan 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.*

Prior Authorization Denials

Refer to the Appeals and Grievances Procedures section of this *policy* for information on your right to *appeal* a denied *authorization.*

Requests for Predeterminations

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

1. The predetermination was based on incomplete or inaccurate information initially received by us.
2. The medical expense has already been paid by someone else.
3. Another party 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 *covered services* sections of this *policy*. All benefits we pay will be subject to all conditions, limitations, and *cost sharing* features of this *policy*. *Cost sharing* means that you participate or share in the cost of your health care services by paying *deductible amounts*, *copayments,* and *coinsurance* for some *covered services*. For example, you may need to pay a *deductible*, *copayment,* or *coinsurance* amount when you visit your *physician* or are admitted into the *hospital*. The *copayment* or *coinsurance* required for each type of service as well as your *deductible* is listed in your *Schedule of Benefits*.

When you, or a covered *dependent 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 expense*s. 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 *copayments* to a *provider* each time services are performed that require a *copayment*. *Copayments,* as shown in the *Schedule of Benefits,* are due at the time of service. Payment of a *copayment* does not exclude the possibility of a *provider* billing you for any non-covered service. *Copayments* do not count or apply toward the *deductible amount* but do apply toward meeting the *maximum out-of-pocket amount*.

Coinsurance Amount

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

Maximum Out-of-Pocket

You must pay any applicable *copayments, coinsurance, or deductible amounts* required until you reach the *maximum out-of-pocket amount* shown in your *Schedule of Benefits*. After the *maximum out-of-pocket amount* is met for an individual, we will pay 100 percent of the cost for *covered services*. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket amount*. For the family *maximum out-of-pocket amount*, once a *member* has met the individual *maximum out-of-pocket amount*, the remainder of the family *maximum out-of-pocket amount* can be met with the combination of any one or more *members' eligible expenses*.

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 amounts, copayment amount* and *coinsurance amounts* are shown in your *Schedule of Benefits*.

Non-Network Liability and Balance Billing

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

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

ACCESS TO CARE

Primary Care Provider
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 or 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 PCP* 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 do not need a referral from your *network PCP* for mental or *behavioral health* services, obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist.

You do need a referral from your *network PCP* to see a *network* dermatologist, but once you have such a referral, you may see that dermatologist without needing further referrals until the earlier of six months or four visits, provided, however, that such visits are related to the issue for which the original referral was made or related complications. In addition, your *network PCP* may make annual referrals for you to see a *network* dermatologist if you have a past history of malignant melanoma.

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 Ambetter.AbsoluteTotalCare.com, or by contacting our office at the number shown on your *member identification card*. The change to your *network PCP* of record will be effective no later than 30 calendar days from the date we receive your request.

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. A licensed nurse is always available and ready to answer your health questions. In an emergency, call 911 or head straight to the nearest emergency room.

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

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*.

Continuity of Care
Under the federal No Surprises Act, if a *member* is a *continuing care patient* with respect to a *network provider* and the contractual relationship with the *provider* is terminated, such that the *provider* is no longer in *network*; or benefits are terminated because of a change in the terms of the participation of the *provider*, as it pertains to the benefit 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 the health plan of the *member*'s need for transitional care; and
3. Permit the member to elect to continue to have their benefits for the course of treatment relating to their status as a *continuing care patient* during the period beginning on the date on which the notice described in (1) is provided and ending on the earlier of:
    a. The 90-days after the notice described in (1) is provided; or
    b. The date on which such *member* is no longer a *continuing care patient* with respect to their provider.

Non-Emergency Services
If you are traveling outside of the South Carolina *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 South Carolina 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.

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.*

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 call us and report your emergency within one business day. You do not need *prior authorization* for emergency services.

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

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

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

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

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

The plan provides coverage for health care services for a *member* or covered *dependent members*. Some services require *prior authorization*. Services should always be provided in the least restrictive clinically appropriate setting. *Deductibles, copayment amounts,* and *coinsurance amounts* must be paid to your *network provider* at the time you receive services. All *covered services* are subject to conditions, exclusions, limitations, terms, and provisions of this *policy*, including, but not limited to, specific benefit, day or visit limits. *Covered services* must be *medically necessary* and not *experimental or investigational*.

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.

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*; and
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 of or slowing of further deterioration. Custodial care and long-term nursing care not covered services under this *policy*.

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

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

Ambulance Services

Air Ambulance Service Benefits

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

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

Non-emergency air ambulance services require *prior authorization. Prior authorization is* not required for emergency ambulance services when the *member* is experiencing an *emergency condition*.

NOTE: You should not be *balance billed* for covered air ambulance services.

Limitations
Benefits for air ambulance services are limited to:

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

Exclusions
No benefits will be paid for:

1. Air ambulance services covered 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 for ground and water transportation, transportation from home, scene of accident or *emergency condition*:

1. In cases where the *member* is experiencing an *emergency condition,* to the nearest *hospital*

that can provide *emergency services* appropriate to 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; or
5. When a *member* is required by us to move from a *non-network provider* to a *network provider*.

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

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

Exclusions
No benefits will be paid for:
1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. 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: evaluation and assessment services;
1. *applied behavior analysis therapy;*
2. behavior training and behavior management;
3. speech therapy;
4. occupational therapy;
5. physical therapy;
6. *behavioral health services* such as counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor, or clinical social worker; and
7. medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

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

Benefit Limitations

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

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 b*ehavioral* h*ealth* 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* (*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 FDA, regardless of whether approved by the FDA for use in treating the patient's particular condition,
2. Reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial and
3. All items and services that are otherwise generally available to a *qualified individual* that are provided in the clinical trial except:
   a. The investigational item or service itself;
   b. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
   c. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

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

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

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

1. One of the NIH;
2. The Centers for Disease Control and Prevention;
3. The Agency for Health Care Research and Quality;
4. The Centers for Medicare & Medicaid Services;
5. A 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 HHS 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*.

Colorectal Cancer Examinations and Laboratory Tests

Covered services include colorectal cancer tests for any non-symptomatic *member*, in accordance with the current American Cancer Society guidelines. *Covered services* include tests for *members* starting at age 45 (**Note:** Screening should start before age 45 for high-risk individuals).

Dental Benefits – Adults 19 years of age or older

Coverage for *dental services* is provided for adults, age 19 and older, for diagnostic and preventive services, basic services and major services rendered by dental providers.

1. Diagnostic and Preventive Services – Class 1 benefits include:
   a. Routine Cleanings;
   b. Oral Examinations;
   c. X-rays – bitewing, full-mouth, and panoramic film; and
   d. Topical fluoride application.
2. Basic Services – Class 2 benefits include:
   a. Minor Restorative – metal or resin-based fillings;
   b. Endodontics – root canals;
   c. Periodontics –scaling and root planing, periodontal maintenance;
   d. Removable prosthodontics –relines, rebase, adjustments and repairs;
   e. Oral *Surgery* – non-surgical and surgical extractions.
3. Major Services – Class 3 benefits include:
   a. Fixed Prosthodontics – crowns and bridges;
   b. Removable Prosthodontics – partial and complete dentures; and
   c. Oral Surgery – impacted and complex extractions, other surgical services.

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

Services not covered include:

1. *Dental services* that are not necessary or specifically covered;
2. Hospitalization or other facility charges;
3. *Prescription drugs* dispensed in the dental office;
4. Any dental procedure performed solely as a cosmetic procedure;
5. Charges for dental procedures completed prior to the *member*'s *effective date* of coverage;
6. Services provided by an anesthesiologist;
7. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to increasing vertical dimension, replacing, or stabilizing or

repairing tooth structure lost by attrition (wear), abfraction, abrasion or erosion, realignment of teeth, periodontal splinting, and gnathological recordings;
8. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles;
9. Any artificial material implanted or grafted into soft tissue or bone, surgical removal of implants, and implant services;
10. Sinus augmentation;
11. Surgical appliance removal;
12. Intraoral placement of a fixation device;
13. Oral hygiene instruction, tobacco counseling, nutritional counseling, or high-risk *substance use disorder* counseling;
14. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture;
15. Any oral *surgery* that includes surgical endodontics (apicoectomy and retrograde filling);
16. Analgesia (nitrous oxide);
17. Removable unilateral dentures;
18. Temporary procedures;
19. Splinting;
20. Temporomandibular joint (TMJ) disorder appliances, therapy, films and arthorograms;
21. Oral pathology laboratory charges;
22. Consultations by the treating provider and office visits;
23. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
24. Veneers (bonding of coverings to the teeth);
25. Orthodontic treatment procedures;
26. Orthognathic *surgery*;
27. Athletic mouth guards; and
28. Space maintainers.

Diabetic Care

Benefits are available for medically necessary items of diabetic supplies used in the treatment of persons with gestational, type I or type II diabetes where such supplies are prescribed by a provider as adopted and published by the Diabetes Initiative of South Carolina.

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, supplies such as urine and/or ketone strips, blood glucose monitors, 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*.

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

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

Dialysis Services
Medically necessary acute and chronic dialysis 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 in a dialysis facility or peritoneal dialysis in your home from a *network provider*.

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

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

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

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

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

Benefits for repairs and replacement do not include the following:

1. Repair and replacement due to misuse, malicious breakage, or gross neglect.
2. Replacement of lost or stolen items.

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

Durable Medical Equipment

The rental (or, at our option, the purchase) of *durable medical equipment* prescribed by a *physician* or other *provider*. 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 costs of 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; if the equipment is owned by the *member*; medically fitting supplies may be paid separately.

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 I.V. fluids and medicine;
5. Glucometer;
6. Tracheotomy tube;
7. Cardiac, neonatal, and sleep apnea monitors; or
8. Augmentative communication devices are covered when we *approve* based on the *member's* condition.

Exclusions

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

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

Durable medical equipment and supplies are subject to *prior authorization* as outlined in 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.

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 the Preventive Care Expense Benefits provision).
6. Med-injectors.
7. Items usually stocked in the home for general use like band-aids, thermometers, and petroleum jelly.

Orthotic Devices
Covered services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are generally included. Applicable tax, shipping, postage, and handling charges are also covered. **NOTE:** 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* under age 18 due to rapid growth, or for any *member* when an *orthotic device* is damaged and cannot be repaired.

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

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

Prosthetics
Artificial substitutes for body parts, 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 implant and bone anchored hearing aids.

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

1. Dentures, replacing teeth, or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports, and corsets.
4. Wigs (except as described above).
5. Penile prosthesis when medical necessity criteria are not met or is strictly a cosmetic procedure.

Emergency Services

If you experience an *emergency condition*, you should call 911 or head straight to the nearest emergency room. We cover emergency services 24 hours a day, seven days a week.

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

Family Planning and Contraception

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

1. The full range of contraceptives currently identified by the U.S. Food and Drug Administration (FDA), including:
   a. sterilization surgery for women,
   b. implantable rods,
   c. copper intrauterine devices,
   d. intrauterine devices with progestin (all durations and doses),
   e. injectable contraceptives,
   f. oral contraceptives (combined pill),
   g. oral contraceptives (progestin only),
   h. oral contraceptives (extended or continuous use),
   i. the contraceptive patch,
   j. vaginal contraceptive rings,
   k. diaphragms,
   l. contraceptive sponges,
   m. cervical caps,
   n. condoms,
   o. spermicides,
   p. emergency contraception (levonorgestrel) and
   q. emergency contraception (ulipristal acetate).
2. Coverage is also available for any additional contraceptives approved, granted, or cleared by the FDA (if the patient and the patient's attending provider have determined it to be medically appropriate).
3. Contraceptive care, such as: screening, education, provision of contraception, counseling, and follow-up care (e.g., management, evaluation, and changes, including the removal, continuation, and discontinuation of contraceptives).
4. Instruction in fertility awareness-based methods, including lactation amenorrhea.

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

Habilitation, Rehabilitation, and Skilled Nursing Facility Expense Benefits

Covered services include services provided or expenses incurred for *habilitation* or *rehabilitation* services or confinement in a *skilled nursing facility*, subject to the following limitations:

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

2. *Rehabilitation* services or confinement in a *rehabilitation facility* or extended care facility must be determined *medically necessary*.
3. *Covered services* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *skilled nursing 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 FDA, unless such drugs or medicines are “off-label drugs” as described under the *Prescription Drug* Expense Benefits heading.
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.
6. Coverage includes cardiac and pulmonary rehabilitation.

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

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

Home Health Care Service Expense Benefits

Covered service expenses 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 only if provided in conjunction with skilled registered nurse or licensed practical nursing service*s*.
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
3. Intravenous (I.V.) medication and pain medication.
4. Skilled services of a *registered nurse* or *licensed practical nurse* rendered on an outpatient basis.
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. If the equipment is purchased, the member must return the equipment to us when it is no longer in use.

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

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

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

Hospice Care Service Expense Benefits

This provision only applies to a *terminally ill member* receiving *medically necessary* care under a *hospice* care program or in a home setting. *Respite care* is covered on an inpatient or home basis to allow temporary relief to family members from the duties of caring for a *member* under hospice care. Respite days that are applied toward the *deductible amount* are considered benefits provided and shall apply against any maximum benefit limit for these services. Benefits for hospice inpatient, home and outpatient care is subject to *prior authorization* as outlined in this *policy*. See your *Schedule of Benefits* for coverage limits.

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, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
6. Counseling the *member* regarding his or her *terminal illness.*
7. *Terminal illness counseling* of the *member's immediate family.*
8. *Bereavement counseling.*

Exclusions and Limitations
Any exclusion or limitation contained in the *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;* or
2. Expenses for other persons, to the extent those expenses are described above, will not be applied to this Hospice Care Service Expense Benefits provision.

Hospital Benefits

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

1. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
2. A private *hospital* room when needed for isolation.
3. Daily room and board and nursing services while confined in an *intensive care unit*.
4. *Inpatient* use of an operating, treatment, or recovery room.
5. Outpatient use of an operating, treatment, or recovery room for *surgery.*
6. Services and supplies, including drugs and medicines, which are routinely provided by the *hospital* 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.

Infertility

Infertility treatment is limited to medical services provided to the *member* which are *medically necessary* for the diagnosis of *infertility* and services required to correct underlying medical conditions

that may cause *infertility* (e.g., endometriosis). This does not include treatment for infertility, including artificial insemination, in vitro fertilization, and other types of artificial or surgical means of conception nor drugs administered in connection with these procedures.

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.

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 6 hours or more/per day
    c. Ventilator management required at least every 4 hours as well as appropriate diagnostic services and assessments
    d. Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions
    e. Patient is hemodynamically stable and not dependent on vasopressors
    f. Respiratory status is stable with maximum PEEP requirement 10 cm H2O, and FiO2 60% or less with O2 saturation at least 90%
    g. Common conditions include complications of acute lung injury, disorders of the central nervous and neuromuscular systems, and cardiovascular, respiratory, and pleural/chest wall disorders.

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

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

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 through 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 with the scope of the practitioner's license.

Maternity Care of the Member

An *inpatient* stay is covered for mother and newborn for a minimum of 48 hours following a vaginal delivery and 96 hours following a delivery by cesarean section will require notification to the health plan. We do not require that a *physician* or other health care provider obtain *prior authorization* for the delivery.

Other *maternity* services that may require *prior authorization* include:

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

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

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

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

Duty to Cooperate

We do not cover services or supplies related to a *member's pregnancy* when a *member* is acting as a

surrogate and has entered into a *surrogacy arrangement*. For more information on excluded services, please see the General Non-Covered Services and Exclusions section. *Members* who are a *surrogate* at the time of enrollment or *members* who agree to a *surrogacy arrangement* during the plan year must, within 30 calendar days of enrollment or agreement to participate in a *surrogacy arrangement*, send us written notice of the *surrogacy arrangement* to **Attn: Compliance, 100 Center Point Circle, Suite 100, Columbia, SC 29210.** In the event that a *member* fails to comply with this provision, we reserve our right to enforce this EOC on the bases of fraud, misrepresentation, or false information, up to and including recoupment of all benefits that we paid on behalf of the *surrogate* during the time that the *surrogate* was insured under 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. *Covered services* for a newborn child include treatment for injury or sickness, medically diagnosed congenital defects, and birth abnormalities.

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

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

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:

1. For *surgery* in a *physician's* office, an *inpatient* facility, 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 *hospital* confined or to have the outpatient *surgery* or procedure.
    b. Bone density studies.
    c. Clinical laboratory tests.
    d. Gastrointestinal lab 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
   For chemotherapy (including oral chemotherapy), inhalation therapy, infusion therapy, and radiation therapy or treatment in a *hospital*, or office setting
4. 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, Medical and Surgical Supplies, Orthotic Devices and Prosthetics provision of this *policy.*
5. For hemodialysis, and the charges by a hospital or facility for the processing and administration of genetic testing, blood, or blood components, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for you.
6. For the cost and administration of anesthesia, oxygen, drugs, medications, and biologicals.
7. 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.
8. For *medically necessary* dental *surgery* due to:
   a. An accidental *injury* which results in damage to natural teeth. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
   b. Surgery to correct a functional defect which results from a congenital and/or acquired disease or anomaly.
   c. Cleft lip and cleft palate for an eligible *member*. *Covered services* includes 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 individual during delivery of any dental treatment or *surgery* if not rendered in a *hospital* or ambulatory surgical center.
      iii. Necessary dental treatment is that which, if left untreated, is likely to result in a medical condition. Use of general anesthesia in a *hospital* or ambulatory surgical center is subject to *prior authorization*. Please call Member Services to confirm your benefits for the use of general anesthesia in a *hospital* or ambulatory surgical center.
9. For *infertility* counseling and planning services when provided by a *network* provider and testing to diagnose infertility, to the extent such services and supplies are legal under *applicable law*.
10. For the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.

11. 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 EOC.
12. For the following types of medically necessary implants and tissue grafts:
    a. Corneal transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.
    e. Implantable prosthetic lenses, in connection with cataracts.
    f. Skin grafts
13. For X-rays, Magnetic Resonance Imaging (MRI), Computer 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*.
14. For *medically necessary* telehealth services. *Telehealth services* 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.
15. For surgery or services related to cochlear implants and bone-anchored hearing aids.
16. For *medically necessary* services for complications arising from medical and surgical conditions.
17. For respiratory, pulmonary, cardiac, physical, occupational, and speech therapy services. Please see Habilitation, Rehabilitation, and Skilled Nursing Facility Expense Benefits provisions of this *policy*.
18. For maternity care services including but not limited to prenatal, postnatal, diagnostic testing, laboratory services, and *hospital* services.
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* footcare treatment that may require *surgery*; *prior authorization* may be required.
21. 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.
22. For *medically necessary* biofeedback services.
23. Therapeutic abortion performed in the case of fetal anomaly or to avoid death or serious risk of substantial and irreversible physical impairment of a major bodily function of the *member* and that is otherwise legal under *applicable law*.
24. For services associated with human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation or transplant procedures.
25. For *medically necessary* chiropractic care or manipulative therapy treatment on an outpatient basis only. See your *Schedule of Benefits* for benefit levels or additional limits. *Covered services* are subject to all other terms and conditions of the *policy*, including the *deductible amount* and *cost sharing* provisions.
26. 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 exams, and pulse oximetry.
27. For *medically necessary* allergy testing and treatment including allergy injections and serum.
28. For medically necessary nutritional counseling, *prior authorization* may be required.

29. 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 services*, for a *member* less than 19 years of age or a *member* who is physically or mentally disabled, are covered if the *member* requires *dental services* 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 services* 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 Disorder (TMJ), including removable appliances for TMJ repositioning and related *surgery*, medical care, and diagnostic services.
   e. Treatment of non-dental lesions, such as removal of tumors and biopsies.
   f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
   g. *Surgical procedures* that are *medically necessary* to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.
   h. *Reconstructive surgery* to correct significant deformities caused by congenital or developmental abnormalities, *illness*, *injury,* or an earlier treatment in order to create a more normal appearance.
2. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* or office charges for dental care, rendered by a dentist, regardless of whether the services are provided in a *network hospital*, surgical center, or office, provided to the following *members*:
   a. A *member* under the age of 19;
   b. A person who is severely disabled; or
   c. A person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

3. Dental service expenses when a *member* suffers an *injury*, that results in:
   a. Damage to his or her natural teeth;
   b. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
4. *Surgery*, excluding tooth extraction, to treat craniomandibular disorders or malocclusions.

Medical Foods

We cover medical foods and formulas for:

1. outpatient total parenteral nutritional therapy;
2. nutritional counseling;
3. outpatient elemental formulas for malabsorption; and
4. dietary formula when *medically necessary* for the treatment of Phenylketonuria (PKU) and inborn errors of metabolism.

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

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

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.
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 and Addiction Equity Act of 2008.

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

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

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

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

Inpatient

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

Outpatient

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

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

In addition, Integrated Care Management is available for all of your health care needs, including be*havioral 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 and may require *prior authorization*:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs. If more than one *prosthetic device* can meet a *member's* functional needs, only the charge for the most cost-effective prosthetic device will be considered a *covered service* expense.
2. For one pair of foot orthotics per year per *member*.
3. For rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
4. For the rental of one Continuous Passive Motion (CPM) machine per covered person following a covered joint *surgery*.
5. For one pair of eyeglasses or contact lenses per covered person following a covered cataract *surgery*.

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; or
2. Standard frames
3. Prescription lenses:
    a. Single;
    b. Bifocal;
    c. Trifocal;
    d. Lenticular; or

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; or
    n. Polycarbonate lenses.
5. Contact lenses and contact lens fitting fee (in lieu of glasses)
6. Low vision evaluation/aids.

Please refer to your *Schedule of Benefits* for a detailed list of *cost sharing*, annual maximum, and appropriate service limitations. To see which vision providers are part of the *network*, please visit Ambetter.AbsoluteTotalCare.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;* and
5. Replacement eyewear.

Prescription Drug Expense Benefits

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

Covered services in this benefit provision are limited to charges from a licensed *pharmacy* for:
1. A *prescription drug.*
2. Prescribed, oral anticancer 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.

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

Cost sharing paid on your behalf for any *prescription drugs* with a generic equivalent will not apply toward your plan *deductible* or your *maximum out-of-pocket amount* if a *drug discount*, *coupon*, *copayment card*, or manufacturer supplied prepaid credit card was used.

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

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

Medication Balance-On-Hand
Medication refills are prohibited until 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.

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

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance, unless listed on the formulary.
2. For immunization agents otherwise not required by the Affordable Care Act.
3. For medication that is to be taken by the *member,* in whole or in part, at the place where it is dispensed.
4. For medication received while the *member* is a patient at an institution, that has a facility for dispensing pharmaceuticals.
5. For a refill dispensed more than 12 months from the date of a *physician's* order.
6. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
7. 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.
8. For drugs labeled "Caution - limited by federal law to investigational use" or for *experimental or investigational* drugs.
9. For more than a 30-day supply when dispensed in any one prescription or refill, or for some maintenance drugs up to a 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply *network*. Specialty drugs and other select drug categories are limited to 30-day supply when dispensed by retail or mail order. **NOTE:** Only the 90

calendar days' supply may be subject to the discounted *cost sharing*. Mail orders less than 90 calendar days are subject to the standard *cost sharing* amount.

10. 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.
11. Off-label use, except as required by law or as expressly approved by us.
12. For any drug that we identify as therapeutic duplication through the Drug *Utilization Review* program.
13. For drugs or dosage amounts determined by Ambetter's Pharmacy and Therapy committee to be ineffective, unproven, or unsafe for the indication for which they have been prescribed, regardless of whether the drugs or dosage amounts have been approved by any governmental regulatory body for that use.
14. Foreign prescription medications, except those associated with an emergency medical condition while you are travelling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this section if obtained in the United States.
15. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
16. 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 for out of country travel. This provision does not prohibit coverage of treatment for aforementioned diseases.
17. Medications used for cosmetic purposes.
18. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status.
19. For any prescription or over-the-counter version of vitamin(s) unless otherwise included on the formulary.
20. Medication refills where a *member* has more than 15 calendar days' supply of medication on hand.
21. Compound drugs unless there is at least one ingredient that is an FDA approved drug.
22. For weight loss prescription drugs, unless otherwise listed on the formulary.
23. For any drug related to *surrogate pregnancy*.
24. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.

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

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

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 *policy* or a protocol exception for step therapy. The request can be made in writing or via telephone. Within 72 hours of the request being received, we will provide the *member*, the *member's* authorized representative or the *member's* prescribing *physician* with our coverage determination. Should the standard exception request or step

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

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

External exception request review
If we deny a request for a standard exception or for an expedited exception, the *member*, the *member's* authorized representative or the *member's* prescribing *physician* may request that the original exception request and subsequent denial of such request be reviewed by an Independent Review Organization ("IRO"). 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-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 contact your *PCP* or provider. Your *PCP* or provider can utilize the usual prior *authorization* request process. See "Prescription Drug Exception Process" for additional details.

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

NOTE: The formulary is not meant to be a complete list of the drugs covered under your prescription benefit. Not all dosage forms or strengths of a drug may be covered. This list is periodically reviewed

and updated and may be subject to change. Drugs may be added or removed, or additional requirements may be added in order to approve continued usage of a specific drug.

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the formulary. For the most current Ambetter Formulary or Prescription Drug List or for more information about our pharmacy program, visit Ambetter.AbsoluteTotalCare.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.

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

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

If you decide to have your *prescription order* filled at a network pharmacy, you can use the Provider Directory to find a pharmacy near you. You can access the Provider Directory at Ambetter.AbsoluteTotalCare.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 Ambetter.AbsoluteTotalCare.com. You can also request to have a copy mailed directly to you.

Mail Order Pharmacy
Mail order pharmacy offers a convenient way to receive your prescriptions. Eligible prescriptions will be safely delivered right to your door at no extra charge to you. You will still be responsible for your regular *copayment*/*coinsurance amount*. To enroll for mail order delivery or for any additional questions, please refer to our Ambetter website, click on "For Member," followed by "Drug Coverage." Under the "Mail Order" section, you will find details on your in-network mail order pharmacies and next steps for enrollment.

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.

Preventive Care Expense Benefits

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

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

Preventive care benefits obtained from a network provider are covered without member cost share (i.e., covered in full without *deductible, 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 Ambetter.AbsoluteTotalCare.com. 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 at least 50 years of age; and at least once annually for a *member* who is less than 50 years of age and who is

at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

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, and ultrasound). *Prior authorization* may be required. See your *Schedule of Benefits* for details. **NOTE:** Depending on the service performed, two bills may be incurred - both subject to any applicable *cost sharing* - one for the technical component (the procedure itself) and another for the professional component (the reading/interpretation of the results by a *physician* or other qualified practitioner).

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

Second Medical Opinion

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

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

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

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 Services

Covered services for transplant service expenses:

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

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

1. Pre-transplant evaluation.
2. Pre-transplant harvesting of the organ from the donor
3. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
4. Including outpatient *covered service*s related to the transplant *surgery*, pre-transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection, and other immunosuppressive drug therapy, etc.
5. Pre-transplant *stabilization*, meaning an *inpatient* stay to medically *stabilize* a member to prepare for a later transplant, whether or not the transplant occurs.
6. The transplant itself, including the acquisition cost for the organ or bone marrow when *authorized* through the C*enter of* E*xcellence* 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 at Ambetter.AbsoluteTotalCare.com/resources/handbooks-forms.html.

Donor Expenses

We will cover the medical expenses incurred by a live donor as if they were medical expenses of the *member* if:

1. They would otherwise be considered *covered service expenses* under the *policy;*
2. The *member* received an organ or bone marrow of the live donor; and
3. The transplant was a *medically necessary* transplant.

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

Ancillary "Center of Excellence" Service Benefits

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 C*enter of* E*xcellence*:
2. We will pay a maximum of $10,000 per transplant for the following services:
   a. Transportation for the *member,* any live donor, and the companions to accompany the *member* to and from the *Center of Excellence,* in the United States.

b. When *member,* donor and/or companion(s) is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
c. Maximum reimbursement for mileage is limited to the total miles traveled by the transplant recipient and by the donor and their respective companion(s), to and from their 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 pay the costs directly for transportation and lodging, and any of the following approved items listed in the *member* transplant guidelines. However, you must make the arrangements and provide the necessary paid receipts for reimbursement within 6 months of the date of service in order to be reimbursed.
e. Please refer to the *member* resources page for *member* reimbursement transplant travel forms and information at Ambetter.AbsoluteTotalCare.com/resources/handbooks-forms.html

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

1. For search and testing in order to locate a suitable donor.
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.
3. For animal to human transplants.
4. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the *Center of Excellence*.
5. To keep a donor alive for the transplant operation, except when *authorized* through the *Center of Excellence*.
6. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
7. Related to transplants *unauthorized* though the *Center of Excellence* and is not included under this provision as a transplant.
8. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the United States FDA regulations, regardless of whether the trial is subject to FDA oversight.
9. The acquisition cost for the organ or bone marrow, when provided at an *unauthorized* facility or not obtained through the *Center of Excellence*.
10. For any transplant services and/or travel related expenses for *member* and donor, when performed outside of the United States.
11. 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 pre-approved by *Case Management*);
    e. Storage rental units;
    f. Temporary housing incurring rent/mortgage payments.
    g. Loss of wages due to time off from work required for transplant for recipient, donor, or companion(s).
    h. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.;

i. Moving violation tickets or parking tickets;
j. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.);
k. Any services related to pet care, boarding, lodging, food, and/or travel expenses;
l. Expenses for persons other than the transplant recipient, donor, or their respective companion(s);
m. Expenses for lodging when the transplant recipient, donor, or their respective companion(s) are staying with a relative, friend or otherwise have free lodging;
n. Any expense not supported by a receipt;
o. Upgrades to first class travel (air, bus, and train);
p. Personal care items (e.g., shampoo, deodorant, clothes);
q. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA pre-check, and early check-in boarding fees, extra baggage fees;
r. Souvenirs (e.g., t-shirts, sweatshirts, toys);
s. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type;
t. All other items not described in the *policy* as eligible expenses; and
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 *PCP* for an appointment before seeking care from another *provider, but* network *urgent care centers* and walk in clinics can be used when an urgent appointment is not available.

If the *PCP* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-833-270-5443. 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.

Vision Benefits - Adults 19 years of age and older

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

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

Please refer to your *Schedule of Benefits* for a detailed list of *member cost sharing*, annual maximum,

and appropriate service limitations. To see which vision providers are part of the *network,* please visit Ambetter.AbsoluteTotalCare.com or call Member Services.

Services not covered:

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

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 AmbetterHealth.com or by contacting Member Services.

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

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

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

You can access other services in connection with this *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 *deductibles, copayments, 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

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.

No benefits will be provided or paid for:

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

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*.
2. For any portion of the charges that are in excess of the *eligible expense.*
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*, bariatric *surgery*, except as specifically covered in the Major Medical Expense Benefits section of this *policy*.
4. For weight loss programs, gym memberships, exercise equipment, or meal preparation programs.
5. For the reversal of sterilization and the reversal of vasectomies.
6. For abortion (except in the case of fetal anomaly or to avoid death or serious risk of substantial and irreversible physical impairment of a major bodily function of the mother when legal under *applicable law*, or as otherwise required under *applicable law*).
7. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered services* of the Major Medical Expense Benefits section.
8. For expenses for television, telephone, or expenses for other persons.
9. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
10. For telephone consultations between providers, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
11. For stand-by availability of a *medical practitioner* when no treatment is rendered.

12. For *dental service* expenses*,* including braces for any medical or dental condition, *surgery,* and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits section.
13. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under this *policy* or is performed to correct a birth defect.
14. Mental health services are excluded:
    a. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
    b. Pre-marital counseling;
    c. Court-ordered care or testing or required as a condition of parole or probation. Benefits will be allowed for services that are *medically necessary* and would otherwise be covered under this *policy*;
    d. Testing of aptitude, ability, intelligence, or interest; and
    e. Evaluation for maintaining employment. Benefits will be allowed for services that would otherwise be covered under this *policy*.
15. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the transplant service provision.
16. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
17. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *policy)*.
18. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*.
19. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *policy*.
20. For hearing aids, except as expressly provided in this *policy*.
21. For *experimental* or *investigational* treatment(s) or *unproven services.* The fact that an *experimental* or *investigational* treatment or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental* or *investigational* treatment or *unproven service* for the treatment of that particular condition.
22. 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 *appeal*ed to the proper governmental agency and the denial is upheld by that agency.
23. For or related to *surrogate* parenting.
24. For fetal reduction *surgery*.
25. 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.
26. 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).

27. 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.
28. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
29. For the following miscellaneous items: artificial insemination (except where required by federal or state law); blood and blood products; care or complications resulting from non-covered services; chelating agents; domiciliary care; food and food supplements**;** 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*.
30. Diagnostic testing, laboratory procedures screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
31. For court ordered testing or care unless *medically necessary*.
32. 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.*
33. Private duty nursing.
34. 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.
35. For any medicinal and recreational use of cannabis or marijuana.
36. *Surrogacy Arrangement*. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a *member*, and any child born as a result of a *surrogacy arrangement*. This exclusion applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the *surrogate* following childbirth);
    d. Mental Health Services related to the *surrogacy arrangement*;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
    h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement*;
    i. Any complications of the child or *surrogate* resulting from the pregnancy; or
    j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*;
    k. Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except where the child is the adoptive child of insureds possessing an active *policy* with us and/or the child possesses an active *policy* with us at the time of birth.

37. Vehicle installations or modifications, which may include, but are not limited to adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.
38. For all health care services obtained at an *urgent care facility,* that is a *non-network provider*.
39. For expenses for services related to dry needling.
40. 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.
41. For expenses, services, and treatments from a Naturopathic *specialist physician* for treatment of prevention, self-healing, and use of natural therapies.
42. For the treatment of *infertility*, except as expressly provided in this *policy*.
43. Assertive Community Treatment (ACT).

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. For a dependent member reaching the limiting age of 26, coverage under this *policy* will terminate at 11:59 p.m. on the last day of the year in which the dependent member reaches the limiting age of 26. The dependent member can be covered beyond the limiting age if they are both (a) incapable of self-sustaining employment by reason of intellectual disability or physical handicap and (b) chiefly dependent upon the policyholder or subscriber for support and maintenance, so long as proof of the incapacity and dependency is furnished to the insurer by the policyholder or subscriber within 60 calendar days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two-year period following the child's attainment of the limiting age;
5. Upon reaching the limiting age, a dependent member may be issued a *policy* providing coverage which is most nearly similar to, but not greater than coverage under which they were formerly covered, if they apply for such coverage within 30 calendar days following the attainment of the limiting age and pay all required premiums;
6. The date of your death if this *policy* is an individual *policy*;
7. 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*;
8. The date a *member's* eligibility for coverage under this *policy* ceases as determined by the Health Insurance Marketplace; or
9. If a dependent *spouse* has had their coverage terminated due to divorce, they may apply for coverage within 60 calendar days and, upon payment of the appropriate premiums, be provided with coverage which is most nearly similar to, but not greater than the coverage which they had received previously as a dependent.

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

If the renewal premium is not paid before the grace period ends the *policy* will lapse. Later acceptance of the premium by us or by an agent *authorized* to accept payment without requiring an application for reinstatement will reinstate the *policy*. If we or our agent requires an application, you will be given a conditional receipt for the premium. If the application is approved, the *policy* will be reinstated as of the approval date. Lacking such approval, the *policy* will be reinstated on the 45th day after the date of the conditional receipt unless we have previously written you of our disapproval. The

reinstated *policy* will cover only *loss* that results from an injury sustained after the date of reinstatement or sickness that starts more than 10 calendar days after such date.

In all other respects your rights and our rights will remain the same, subject to any provisions noted on or attached to the reinstated *policy*. Any premiums we accept for reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 calendar days before the reinstatement date. This applies only to policies for which you are not receiving a premium subsidy.

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 *injuries* or *illness* to a *member*. Such *injuries* or *illness* is 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 *policy* provides benefits 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; and
5. Any other payments from a source intended to compensate a *member* for *third party* injuries.

By accepting benefits under this plan, the *member* specifically acknowledges our right of recovery. When this plan 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 plan. We may proceed against any party with or without the *member's* consent.

By accepting benefits under this plan, the *member* also specifically acknowledges our right of reimbursement. This right of reimbursement attaches when this plan has provided health care benefits for expenses incurred due to *third party* injuries and the *member* or the *member's* representative has recovered any amounts from any source. 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 plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement).
5. To pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due us as reimbursement for the full cost of all benefits associated with *Third Party* injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement).
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 plan.
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 plan in addition to costs and attorney’s fees incurred by us.

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

CLAIMS

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

Proof of Loss
We must receive written *proof of loss* within 90 calendar days of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than one year late will not be accepted unless you or your covered *dependent member* had no legal capacity to submit such proof during that year. When we receive notice of claim, we will send the *claimant* forms for filing proof of *loss*. If these forms are not given to the *claimant* within 15 calendar days, the *claimant* will meet the proof of *loss* requirements by giving us a written statement of the nature and extent of the *loss* within the time limits stated in this *Proof of Loss* section.

How to Submit a Claim
Providers will typically submit claims on your behalf, but sometimes you may need to submit claims yourself for *covered service*s. 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, copayment amounts* 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 *pr*ovider. You also need to submit a copy of the *member* reimbursement claim form posted at Ambetter.AbsoluteTotalCare.com under “For Members – Forms and Materials.” Send all the documentation to us at the following address:

Ambetter from Absolute Total Care
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

For services that do not fall under the federal No Surprises Act *balance billing protections*, after receiving written *proof of loss*, Ambetter from Absolute Total Care will process within 40 business days for clean claims filed on paper and within 20 business days for clean claims filed electronically all benefits then due during the *calendar year* 2024. For services that fall under the federal No Surprises Act *balance billing protections*, we will process a clean claim within 30 calendar days of receipt. Benefits will be paid to you, or to the provider to whom you have assigned payment of benefits. "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 if it was submitted electronically and within 40 calendar days if it was submitted on paper. We will complete our processing of the claim within 30 calendar days after our receipt of all requested information.

Payment of Claims

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

Change of Beneficiary

The insured can change the beneficiary at any time by giving the company written notice. The beneficiary's consent is not required for this or any other change in the *policy* unless the designation of the beneficiary is irrevocable.

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 calendar days.

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

translation, at the *member's* expense to show proper *proof of loss* and evidence of payment to the *provider*.

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

The amount of reimbursement will be based on the following:

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

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

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.

Medicare

This provision describes how we coordinate and pay benefits when a *member* is also enrolled in Medicare and duplication of coverage occurs. If a *member* is not enrolled in Medicare or receiving benefits, there is no duplication of coverage and we do not have to coordinate with Medicare.

The benefits under this *policy* are not intended to duplicate any benefits to which *members* are entitled under Medicare.

Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status and will be adjudicated by us as set forth in this section. In cases where Medicare or another government program has primary responsibility, Medicare benefits will be taken into account for any *member* who is enrolled for Medicare. This will be done before the benefits under this *policy* are calculated. When Medicare, Part A and Part B or Part C is primary, Medicare's allowable amount is the highest allowable expense.

When a person is eligible for Medicare benefits and Medicare is deemed to be the primary payer under Medicare secondary payer guidelines and regulations, we will reduce our payment by the Medicare primary payment and pay as secondary up to the Medicare allowable amount. However, under no circumstances will this *policy* pay more than it would have paid if it had been the primary plan.

Charges for services used to satisfy a *member's* Medicare Part B *deductible* will be applied in the order received by us. Two or more expenses for services received at the same time will be applied starting with the largest first.

This provision will apply to the maximum extent permitted by federal or state law. We will not reduce the benefits due any *member* because of a *member's* eligibility for Medicare where federal law requires that we determine its benefits for that *member* without regard to the benefits available under Medicare.

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

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 service expenses* under that program.

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

Custodial Parent

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

Upon request by the custodial parent, we will:

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

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

In addition, we will:

1. Permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;
2. If the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of:
   a. the child's other parent;
   b. the state agency administering the Medicaid program; or

c. the state agency administering 42 U.S.C. Sections 651 to 669, the child support enforcement program; and

3. Continue coverage of the child unless the insurer is provided satisfactory written evidence that the:
   a. court order is no longer in effect;
   b. child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the *effective date* of disenrollment; or
   c. employer has eliminated family health coverage for all of its employees.

Physical Examination

We shall have the right and opportunity to examine a *member* while a claim is pending or while a dispute over the claim is pending. These examinations are made at our expense and as often as we may reasonably require. In cases of death of the *member*, we may have an autopsy performed during the period of contestability at our own expense unless prohibited by law. The autopsy must be performed in South Carolina.

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 six years after the date *proof of loss* is required.

Non-Assignment

The coverage, rights, privileges, and benefits provided for under this *policy* are not assignable by you or anyone acting on your behalf. Any assignment or purported assignment of coverage, rights, privileges, and benefits provided for under this *policy* that you may provide or execute in favor of any *hospital, provider*, or any other person or entity shall be null and void and shall not impose any obligation on us.

No Third-Party Beneficiaries

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

APPEALS AND GRIEVANCES PROCEDURES

Internal Procedures

Applicability/Eligibility

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

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

An appeal is the request for us to reconsider a previous decision regarding an adverse benefit determination, including adverse medical necessity and benefit decisions.

When we make an *adverse benefit determination*, we will send the *claimant* and/or their *authorized representative* a notification that includes information to file an *appeal* and how to authorize a representative. *Claimant*s have 180 calendar days to file an *appeal* from the date we issue the *adverse benefit determination.* A grievance may be filed at any time.

An eligible appeal 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.
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*.

An appeal is the request for Ambetter to reconsider a previous decision regarding an adverse benefit determination, including adverse medical necessity and benefit decisions.

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

Ambetter from Absolute Total Care
Attn: Grievances and Appeals Department
PO Box 10341
Van Nuys, CA 91410
Fax: 1-833-886-7956

*Claimant*s can also file an *appeal* via phone by contacting Member Services. Verbal requests must be followed up in writing.

*Claimant*s have the right to submit written comments, documents, records, and other information relating to the claim for benefits. *Claimant*s 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 Member Services if you have any questions regarding the process or how to file an *appeal*. We will get an interpreter or Relay services for you if you need them.

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 calendar days of receipt of the *appeal*. If an authorized representative is elected, the resolution time clock begins after Ambetter receives written consent from the member, parent, or legal guardian. 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 as the provider who requested the service will review the request and make a determination. This reviewer will not be the individual involved in the original decision or a subordinate.

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

1. The *claimant* will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. We will give the *claimant* 10 calendar days to respond to the new information before making a determination. The *claimant* will have the option of delaying the determination for a reasonable period of time to respond to the new information; or
2. The *claimant* will receive from us, as soon as possible, any new or additional medical rationale considered by the reviewer. We will give the *claimant* 10 calendar days to respond to the new

medical rationale before making a determination. The *claimant* will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.

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

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.

Claimants can file an expedited *appeal* by phone through Member Services or in writing by sending an appeal form or letter to:

Ambetter from Absolute Total Care
Attn: Grievances and Appeals Department
PO Box 10341
Van Nuys, CA 91410

We will make a decision about your expedited *appeal* request within 72 hours. We will notify you or your authorized representative and your provider of the result. Due to the 72-hour resolution timeframe, the standard requirements for notification, and acknowledgement do not apply to *expedited appeals.*

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

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

Written Appeal Response

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

1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *appeal*;
3. If upheld or partially upheld, it is also necessary to include:
   a. A clear explanation of the decision;
   b. Reference to the specific *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

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. You must make your request for an external review in writing within four months of receiving notice that an adverse decision has been made under our internal *appeal* process. 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. 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 *IRO* from the South Carolina Department of Insurance. We submit this request to:

Director Michael Wise
South Carolina Department of Insurance
P.O. Box 100105
Columbia, South Carolina 29202-3105
Phone: 1-803-737-6150

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

1. The internal *appeal* process must be exhausted before the *claimant* may request an external review unless the *claimant* files a request for an expedited external review at the same time as an internal *expedited grievance* or we either provide a waiver of this requirement or fail to follow the *appeal* process;
2. A health plan must allow a *claimant* to make a request for an expedited external review with the plan at the time the *claimant* receives:
    a. An *adverse benefit determination* if the determination involves a medical condition of the *claimant* for which the timeframe for completion of an internal *expedited grievance* would seriously jeopardize the life or health of the *claimant* or would jeopardize the *claimant*'s ability to regain maximum function, or when an *adverse benefit determination* involves a denial of a *prior authorization* request or claim for a recognized diagnostic imaging service for a *member's* stage four advanced metastatic cancer, and the *claimant* has filed a request for an internal *expedited grievance*; 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. *Claimant*s may request an expedited external review at the same time the internal *expedited grievance* is requested and an (IRO) will determine if the internal *expedited grievance* 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; or
2. A determination of whether *surprise billing protections* apply and the *member cost sharing* that applies for services subject to *surprise billing protections*; or *rescissions* of coverage.

External Review Process

1. You have four months to request a standard external review and there is no time frame to request an expedited external review.
2. We have five business days (immediately for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether:
    a. The individual was a covered person at the time the item or service was requested;
    b. The service is a *covered service* under the *claimant*'s *policy* but for the policy's *adverse benefit determination* with regard to medical necessity *experimental or investigational*, medical judgment, or *rescission*;
    c. The *claimant* has exhausted the internal process; and
    d. The *claimant* has provided all of the information required to process an external review.
3. Within one business day (immediately for expedited) after completion of the preliminary review, we will notify the *claimant* in writing as to whether the request is complete but not eligible for external review and the reasons for its ineligibility or, if the request is not complete, the additional information needed to make the request complete;
4. We must allow a *claimant* to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of notification;

5. We will notify the Department of the *claimant's* request for external review;
6. The Department will assign an IRO on a rotating basis;
7. We will verify that no conflict of interest exists with the assigned IRO (if a conflict does exist, we will contact the Department for an additional assignment);
8. Within five business days of the Department's assignment of an IRO, we will notify the *claimant* in writing of the assignment to an IRO and the *claimant*'s right to submit additional information to be considered by the IRO. If the *claimant* provides the IRO information within the five-day timeframe, the information will be considered in the review. This information must be shared with us within one business day of receipt by the IRO.
9. Within five business days after the date of assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO.
   Note: For expedited, after assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method;
10. If we fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the *adverse benefit determination*;
11. Within 10 business days, the assigned IRO will timely notify the *claimant* in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the *claimant* may submit in writing additional information to the IRO to consider;
12. Upon receipt of any information submitted by the *claimant*, the IRO must forward the information to us within one (1) business day;
13. Upon receipt of the information, we may reconsider our determination. If we reverse our *adverse benefit determination*, we must provide written notice of the decision to the *claimant* and the IRO within one business day after making such decision. The external review would be considered terminated;
14. Within 45 calendar days (72 hours for expedited) after the date of receipt of the request for an external review by the health plan, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to the *claimant* and to us. If the notice for an expedited review is not in writing, the IRO must provide written confirmation within 48 hours after the date of providing the notice; and
15. Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, we will approve the benefit that was the subject of the *adverse benefit determination*.

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*. The *claimant* or their *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 *policy* 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 *policy*.

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;

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

Ambetter from Absolute Total Care
Attn: Grievances and Appeals Department
P.O. Box 10341
Van Nuys, CA 91410

If filing a written *grievance*, please include:
1. Your first and last name
2. Your *member* identification number
3. Your address and telephone number
4. Details surrounding your concern
5. Any supporting documentation

Applicability/Eligibility

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

An eligible grievant is:
1. A *claimant*;
2. Person authorized to act on behalf of the *claimant*. 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 calendar days of receipt of your *grievance*.

*Grievance*s will be promptly investigated and will be resolved within 30 calendar days of receipt. The time period may be extended for an additional 14 calendar days, making the maximum time for the entire *grievance* process 44 calendar days if we provide you or your *authorized representative*, if applicable, written notification of the following within the first 30 calendar days:
1. That we have not resolved the *grievance*;
2. When our resolution of the *grievance* may be expected; and
3. The reason 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 Insurance Department

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

Appeals and Grievances filing and key communication timelines

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

GENERAL PROVISIONS

Entire Policy

This *policy,* with the enrollment application, *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; or
4. Waive any of our rights or requirements.

Non-Waiver

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

Rescissions

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

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

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*.

Time Limit on Certain Defenses

After two years from the issue date of the fraud, misrepresentation or knowingly provides false information in the application may be used to void the *policy* or deny any claim for *loss* incurred or disability that starts after the two-year period. You have the right to continue your *policy* with us by a payment of premium (A) until at least age 50 or (B) in the case of a *policy* issued after age 44, for at least five years from its date of issue. After this *policy* has been in force for two years, we will not contest the statements contained in the application. Any *loss* or disability claims that start after two years from the date of insurance will not be reduced or rejected, because there was an *illness* or physical condition before the *effective date* of the insurance, and there was no *illness* before the insurance date.

Conformity with Applicable Laws

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

Personal Health Information (PHI)

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

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

Language

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

English:	If you, or someone you are helping, have questions about Ambetter from Absolute Total Care, 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 1-833-270-5443 (Relay 711).
Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from Absolute Total Care 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 1-833-270-5443 (Relay 711).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Absolute Total Care 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 1-833-270-5443 (Relay 711)。
Vietnamese:	Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter from Absolute Total Care 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 1-833-270-5443 (Relay 711).
Korean:	귀하 또는 귀하의 도움을 받는 분이 Ambetter from Absolute Total Care에 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 1-833-270-5443 (Relay 711)번으로 가입자 서비스부에 연락해주십시오.
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Absolute Total Care 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 1-833-270-5443 (Relay 711).
Tagalog:	Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Ambetter from Absolute Total Care, 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 1-833-270-5443 (Relay 711).

Russian:	Если у вас или у лица, которому вы помогаете, возникли какие-либо вопросы о программе страхования Ambetter from Absolute Total Care, при этом вы недостаточно хорошо владеете английским языком, вы имеете право на бесплатную и своевременную помощь и информацию на своем родном языке. Если у вас или у лица, которому вы помогаете, наблюдается какое-либо нарушение слуха и/или зрения, которое препятствует коммуникации, вы имеете право на бесплатные и своевременные вспомогательные услуги и помощь. Для получения услуг перевода или вспомогательных услуг обратитесь в отдел обслуживания участников программы страхования по номеру 1-833-270-5443 (Relay 711).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Absolute Total Care 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 1-833-270-5443 (Relay 711).
Gujarati:	જો તમને અથવા તમે જેમની મદદ કરી રહ્યા હો એવી કોઈ વ્યક્તિને Ambetter from Absolute Total Care 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 1-833-270-5443 (Relay 711) પર સભ્યની સેવાઓનો સંપર્ક કરો.
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Absolute Total Care، ولم تكن بارعًا باللغة الإنكليزية، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت أنت أو أي شخص تساعده تعاني من حالة سمعية و/أو بصرية تعيق التواصل، فلديك الحق في تلقي مساعدات وخدمات إضافية من دون أي تكلفة وفي الوقت المناسب. لتلقي خدمات الترجمة أو خدمات إضافية، يرجى الاتصال بـ خدمات الأعضاء على (Relay 711) 1-833-270-5443.
Portuguese:	Se tiver dúvidas acerca da Ambetter from Absolute Total Care, ou estiver a ajudar uma pessoa com dúvidas acerca desta, e não dominar o inglês, tem o direito de obter ajuda e informações no seu idioma sem qualquer custo e de forma atempada. Se tiver uma condição visual e/ou auditiva que dificulte a comunicação ou estiver a ajudar uma pessoa com uma condição deste tipo, tem o direito de receber equipamentos ou serviços de assistência sem qualquer custo e de forma atempada. Para receber traduções ou serviços de assistência, contacte serviços de membro através do número 1-833-270-5443 (Relay 711).
Japanese:	ご自身やあなたが介護している他の人が、Ambetter from Absolute Total Careについてご質問をお持ちの場合、英語に自信がなくても無料かつタイムリーにご希望の言語でヘルプや情報を得ることができます。ご自身や、あなたが介護している他の人の聴覚や視覚の状態のためやり取りが難しい場合でも、無料かつタイムリーに補助サービスを受けることができます。翻訳や補助サービスを受けるには、1-833-270-5443 (Relay 711)のメンバーサービスにご連絡ください。
Ukrainian:	Якщо у вас або особи, якій ви допомагаєте, виникли запитання щодо плану Ambetter from Absolute Total Care, але ви чи ця особа не володієте англійською мовою, ви маєте право отримати допомогу та інформацію своєю мовою безкоштовно й своєчасно. Якщо у вас або особи, якій ви допомагаєте, є вади слуху або зору, які заважають спілкуванню, ви маєте право отримати допоміжні засоби та послуги безкоштовно й своєчасно. Щоб отримати переклад або додаткові послуги, зв'яжіться зі Службою обслуговування учасників за номером 1-833-270-5443 (Relay 711).

Hindi:	अगर आप या कोई ऐसा व्यक्ति जिसकी आप सहायता कर रहे हैं, के पास Ambetter from Absolute Total Care 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 1-833-270-5443 (Relay 711) पर सदस्य सेवाएं से संपर्क करें.
Mon-Khmer, Cambodian:	ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពី Ambetter from Absolute Total Care ហើយមិនមានភាពស្ទាត់ជំនាញក្នុងការប្រើភាសាអង់គ្លេស អ្នកមានសិទ្ធិទទួលបានជំនួយ និងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ និងទៅតាមពេលវេលាសមស្រប។ ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានបញ្ហាគំហើញ និង/ឬការស្តាប់ដែលរារាំងដល់ការទំនាក់ទំនង អ្នកមានសិទ្ធិទទួលបានជំនួយ និងសេវាកម្មចាំបាច់នានាដោយឥតគិតថ្លៃ និងក្នុងពេលវេលាសមស្រប។ ដើម្បីទទួលបានសេវាកម្មបកប្រែ ឬសេវាកម្មចាំបាច់នានា សូមទាក់ទងសេវាកម្មសមាជិក តាមរយៈលេខ 1-833-270-5443 (Relay 711)។

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