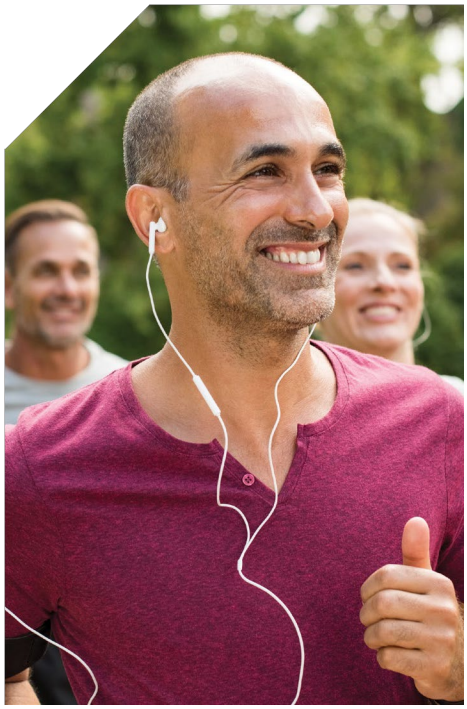
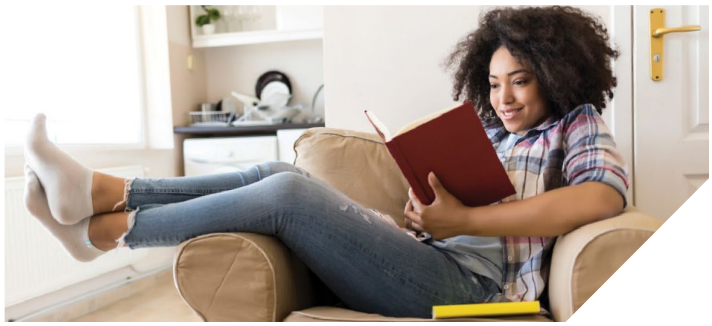


2026 EVIDENCE OF COVERAGE

Ambetter Health
Underwritten by Celtic Insurance Company



AmbetterHealth.com/en/NE

13484NE009-2026

AMBETTER HEALTH

Underwritten by Celtic Insurance Company

Ambetter

Home Office: 2525 N. 117th Avenue, Ste. 100, Omaha, NE 68164

Individual Major Medical Expense EPO Insurance Policy

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

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

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

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

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

RIGHT TO RETURN POLICY

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

Celtic Insurance Company

Kevin J. Counihan, CEO

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INTRODUCTION

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

It describes:

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

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

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

How to Contact Us

Ambetter Health
2525 N. 117th Avenue, Suite 100
Omaha, NE 68164

Normal Business Hours of Operation 8:00 a.m. to 8:00 p.m. local time, Monday through Friday.
Member Services 1-833-890-0329
TTY line 711
Email ..... Secure email function within the Online Member Account
Emergency 911
Suicide and Crisis Lifeline . 988 (call or text) 24/7
Nurse Advice Line ..... 1-833-890-0329 or for the hearing impaired (TTY 711)

Interpreter Services

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

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

To arrange for interpreter services, please call Member Services.

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

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

You have the right to:

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

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 physician(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*. Your *PCP* can discuss different treatment plans with you, if there is more than one plan that may help you. You will make the final decision.
18. Select your *PCP* within the *network*. You also have the right to change your *PCP* or request information on *network providers* close to your home or work.
19. Know the name and job title of people giving you care. You also have the right to know which physician is your *PCP*.
20. An interpreter when you do not speak or understand the language of the area.
21. A second opinion by a *network physician*, if you want more information about your treatment or would like to explore additional treatment options.
22. Make advance directives for healthcare 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 directives are forms you can complete to protect your rights for medical care. It can help your *PCP* and other *providers* understand your wishes about your health. Advance directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself. Examples of advance directives include:
    a. Living Will.

b. Health Care Power of Attorney; or

c. “Do Not Resuscitate” orders. *Members* also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive.

You have the responsibility to:

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

IMPORTANT INFORMATION

Provider Directory

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

You may also contact Member Services or through the website at AmbetterHealth.com/en/NE 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 us. 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-n*etwork *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 PCP* for each member. We can also help you pick a *PCP*. We can make your choice of *PCP* effective on the next business day.

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

Member Identification Card

We will mail you a member identification card after we receive your completed enrollment material and you have paid your initial premium payment. This card is proof that you are enrolled in the Ambetter plan. You need to keep this card with you at all times. Please show this card every time you go for any service under the policy. Your member identification card will show your name, member identification number, the phone numbers for Member Services, pharmacy and 24/7 Nurse Advice Line and *copayment amounts* required at the time of service. Any applicable *deductibles,* and any applicable *out-of-pocket maximum amounts* 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 and we will send you another card.

Website

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

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

5. Notice of Privacy Practices.
6. Current events and news.
7. Our formulary or *prescription drug* list.
8. *Deductible* and *copayment* accumulators.
9. Selecting a *PCP*.

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

Quality Improvement

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

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

For example, if you have a concern about the care you received from your *network 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 healthcare and services you are receiving. The results of the survey will be made available to you upon your request.

Protection from Balance Billing

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

DEFINITIONS

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

Wherever used in this *policy*:

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

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

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

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

1. A denial of a request for service.
2. A denial, reduction, or failure to provide or make payment in whole or in part for a covered service.
3. A determination that an admission, continued stay, or other health care service does not meet our requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness.
4. A determination that a service is experimental, investigational, *cosmetic treatment*, not *medically necessary* or inappropriate.
5. Our decision to deny 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 Grievance and Complaint Procedures section of this *policy* for information on your right to *appeal* an *adverse benefit determination*.

Adverse determination means a determination by a health carrier or its designee *utilization review* agent that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements

for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested health care service is therefor denied, reduced, or terminated.

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

NOTE: If you receive services from a *non-network provider*, you may be responsible for the difference between the amount the *provider* charges for the service (*billed amount*) and the *allowed amount* that we pay. However, you will not be responsible for balance billing for unanticipated out-of-network care that 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.

Ambetter-designated telehealth provider means the vendor selected by Ambetter to contract with *providers* to render *telehealth services*, including Virtual Primary Care and *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.

Ambulatory 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.

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

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

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

Authorization or authorized (also "*prior authorization*" or "approval") means a decision to approve specialty or other *medically necessary* care for a *member* by the *member's PCP* or *provider*.

Authorized representative means:

1. A person to whom a covered person has given express written consent to represent the covered person in an external review.
2. A person *authorized* by law to provide substituted consent for a covered person; or
3. A family member of the covered person or the covered person's treating health care professional only when the covered person 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 protections means the protections against balance billing under the federal No Surprises Act or Nebraska law. 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 facility* 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 includes both mental health and *substance use disorder*, encompassing a continuum of prevention, intervention, treatment, and recovery support services.

Benefits or ***covered benefits*** means those health care services to which a covered person is entitled under the terms of a health benefit plan.

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

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

Bone marrow transplant means a procedure in which bone marrow from a related or non-related donor is infused into the transplant recipient or is derived from the same person who is the recipient and includes peripheral blood stem cell transplants.

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

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

Center of Excellence means a *hospital* that:

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

Certification means a determination by a health carrier or its designee *utilization review* agent that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

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

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

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

Complications of pregnancy means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dental 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 membe*r.

Director means the *Director* of Insurance.

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

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

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

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

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

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

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

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

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

Emergency services means *covered services* needed to evaluate and *stabilize* an *emergency condition*. This includes a medical screening examination in a *hospital* emergency department (including labor and delivery departments) or independent freestanding emergency department to evaluate the *emergency condition,* as well as services needed to *stabilize* the *emergency condition*. Services to *stabilize* an *emergency condition* can be provided in any department of a *hospita*l.

Follow-up care is not considered emergency care. *Benefits* are provided for treatment of *emergency conditions* and emergency screening and stabilization services without *prior authorization*. *Benefits* for emergency care include facility costs and *physician* services and supplies and *prescription drugs* charged by that facility. You must notify us or verify that your *physician* has notified us of your admission to a *hospital* within 48 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the *inpatient* setting is appropriate, and if appropriate, the number of days considered *medically necessary*. By contacting us, you may avoid financial responsibility for any *inpatient* care that is determined to be not *medically necessary* under your *policy*. If your *provider* does not contract with us, you will be financially responsible for any care we determine is not *medically necessary.* Care and treatment provided once you are medically *stabilized* is no longer considered emergency care. Continuation of care from a *non-network provider* beyond what is needed to evaluate or *stabilize* your condition in an emergency will be covered as a non-network 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 (www.healthcare.gov). If you have utilized enroll.AmbetterHealth.com to apply or renew, a consumer dashboard has been created for you. You can access your consumer dashboard at enroll.AmbetterHealth.com.

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

1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the claimant or the ability of the claimant to regain maximum function.
2. In the opinion of a *physician* with knowledge of the claimant's medical condition, the claimant is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*.
3. A *physician* with knowledge of the claimant's medical condition determines that the *grievance* shall be treated as an *expedited grievance*.

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

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (FDA) regulation, regardless of whether the trial is subject to FDA oversight;
2. An *unproven service*;
3. Subject to FDA approval, and:
    a. It does not have FDA approval;
    b. It has FDA approval, only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has FDA approval but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of an FDA-approved drug is a use that is determined by us to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or

iii. Not an *unproven service*; or

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

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

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

Final adverse determination means an *adverse determination* involving a covered benefit that has been upheld by a health carrier, or its designee *utilization review* organization, at the completion of the health carrier's internal *appeal* process procedures.

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 a written *complaint* submitted in accordance with the health plans' formal *grievance* procedure by or on behalf of a covered person regarding any aspect of the *managed care plan*, relative to the covered person, such as:

1. Availability, delivery, or quality of health care services.
2. Claims payment, handling, or reimbursement for health care services; or
3. Matters pertaining to the contractual relationship between a covered person and a health carrier.

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

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

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

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

1. Provided by a *home health care agency*; and

2. Prescribed and supervised by a *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 not expected to live for more than 6 months, as certified by a *network physician*. We work with certified *hospice* programs licensed by the state to minimize patient discomfort and address the special physical, psychological, and social needs of *terminally ill members* and their *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; an *extended care facility*, nursing, rest, *custodial care,* or convalescent home; a halfway house, transitional facility, or *residential treatment facility*; a place for the aged, drug addicts, alcoholics, or runaways; a facility for wilderness or outdoor programs; or a similar establishment.

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

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

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

Independent review organization (***IRO***) means an entity that conducts independent external reviews of *adverse determinations* and *final adverse determinations*.

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 services, supplies, or treatment for a medical condition or, *behavioral health*, are received by a person who is an overnight resident patient of a *hospita*l 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*.

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

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

Managed care plan means a health benefit plan, including closed plans and open plans, that either requires a covered person to use or creates financial incentives by providing a more favorable *deductible*, coinsurance, or *copayment* level for a covered person to use health care *providers* managed, owned, under contract with, or employed by the health carrier.

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

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

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

Medical practitioner includes but is not limited to a *physician*, nurse anesthetist, *physician's* assistant, physical therapist, or midwife. The following are examples of *providers* that are NOT *medical practitioners*, by definition of the *policy*: acupuncturist, speech therapist, occupational therapist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, emergency medical technician, social worker, family counselor, marriage counselor, child counselor, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or *certification*.

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

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

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

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

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

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

Necessary medical supplies means medical supplies that are:

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

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

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

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

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

Non-elective cesarean section means:

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

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

1. *Emergency services*, as described in the *covered services* section of this *policy*.
2. Non-emergency healthcare services received at a *network facility*, as described in the Managing Your Healthcare section of this *policy*; or
3. A situation 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 provide*r provides the *membe*r 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, *hospital*ists, and intensivists). *Notice and consent* will waive *balance billing protections* for *post-stabilization services* only if all the following additional conditions are met:

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

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

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

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

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

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

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

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

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

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

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

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

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

Prosthetic device means a *medically necessary* device used for 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 means any *physician*, *hospital*, or other person licensed or otherwise *authorized* to furnish health care services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Retrospective review means a review of medical necessity conducted after services have been provided to a patient but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

Schedule of benefits means a summary of the *deductible*, *copayment amount*, coinsurance, *maximum out-of-pocket*, 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.

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

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

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

Social determinants of health 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, or treat certain types of symptoms and conditions related to their specific field of expertise.

Spouse means your lawful wife or husband.

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

Stabilize, with respect to a *member* who has experienced an *emergency condition*, means to provide medical treatment of the condition as necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer* of the *member* to another facility or discharge of the *member* (*See Ambulance Service Benefits provision under the Major Medical Expense Benefit section).

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

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

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

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

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

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

Telehealth services means the use of medical information electronically exchanged from one site to another, whether synchronously or asynchronously, to aid a health care *provider* in the diagnosis or treatment of a patient. Telehealth includes services originating from a patient's home or any other location where such patient is located, asynchronous services involving the acquisition and storage of medical information at one site that is then forwarded to or retrieved by a health care *provider* at another site for medical evaluation, and telemonitoring.

Telemedicine services means health care services delivered by use of interactive audio, video, or other electronic media, including the following:

1. Medical examinations and consultations; and,
2. *Behavioral health*, including *substance use disorder* evaluations and treatment.

The term does not include the delivery of health care services by use of the following:

1. A telephone transmitter for trans-telephonic monitoring; or,
2. A telephone or any other means of communication for the consultation from one (1) *provider* to another *provider*.

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

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

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

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

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

Unproven service(s) means services, including medications that are determined not to be effective for treatment of the medical condition, or not to have a beneficial effect on health outcomes, due to

insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or well-conducted cohort studies in the prevailing published peer-reviewed medical literature.

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

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

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

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

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

Written means transmission of correspondence by mail, facsimile, or electronic medium.

DEPENDENT MEMBER COVERAGE

Dependent Member Eligibility

Your *dependent members* become eligible for insurance on the latter of:

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

Effective Date for Initial Dependent Members

Dependent members included in the 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 calendar day after birth, unless we have received notice from the entity that you have enrolled (either the Health Insurance Marketplace or us). Each type of *covered service* incurred by the newborn child will be subject to the *cost sharing* amount listed in the *Schedule of Benefits*, including coverage for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

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

Coverage for an Adopted Child

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

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

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

from the Marketplace within 60 calendar days of the birth or placement and b) any additional premium required for the addition of the child within 90 calendar days of the date of placement.

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

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

Adding Other Dependent Members

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

ELIGIBILTY AND ENROLLMENT

For All Members

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

1. The date that a *member* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *policy*.
2. The date we receive a request from you to terminate this *policy*, or any later date stated in your request, or if you are enrolled through the Marketplace, the date of termination that the Marketplace provides us upon your request of cancellation to the Marketplace.
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 (e.g., the date that a *member* accepts any direct or indirect contributions or reimbursement by or on behalf of an employer, for any portion of the premium for coverage under this *policy*); or
5. The date of a *member's* death.
6. The *subscriber* residing outside the *service area* or moving permanently outside the *service area* of this plan.

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

For Dependent Members

A *dependent member* will cease to be a *member* at the end of the premium period in which he or she ceases to be your *dependent member* due to divorce or if a child ceases to be an *eligible child*. For *eligible children*, the coverage will terminate the thirty-first day of December the year the dependent turns 26 years of age. An *eligible child* who attains the age of 26 shall not have coverage terminated while the *policy* is still in effect and while the *eligible child* is and continues to be both:

1. Incapable of self-sustaining employment by reason of an intellectual disability or a physical disability and;
2. Chiefly dependent upon the policyholder for support and maintenance, if proof of such incapacity and dependency is furnished to the insurer by the policyholder within 31 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. An additional premium may apply as determined by us.

Open Enrollment

There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 1, 2025 and extends through January 15, 2026. *Qualified individual*s who enroll on or before January 15, 2026 will have an *effective date* of coverage on January 1, 2026.

Special Enrollment Periods

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

1. A *qualified individual* or dependent 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 *member'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.
3. In the case of marriage, at least one *spouse* must demonstrate having *minimum essential coverage* as described in 26 C.F.R 1.5000A-(b) for one or more days during the 60 calendar days preceding the date of marriage.
4. An individual, who was not previously a citizen, national, or lawfully present individual gains such status.
5. An individual who is no longer incarcerated or whose incarceration is pending the disposition of charges.
6. A *qualified individual's* enrollment or non-enrollment in a *qualified health plan* is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace or HHS, or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.
7. A *membe*r adequately demonstrates to the Health Insurance Marketplace that the *qualified health plan* in which he or she is enrolled substantially violated a material provision of its *policy* in relation to the *member's* decision to purchase the *qualified health plan* based on plan *benefits*, *service area* or premium.
8. An individual is determined newly eligible or newly ineligible for *advance premium tax credits* or has a change in eligibility for *cost sharing reductions*, regardless of whether such individual is already enrolled in a *qualified health plan*.
9. A *qualified individual* or *member* gains access to new *qualified health plans* as a result of a permanent move.
10. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended.
11. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a *qualified health plan* or change from one *qualified health plan* to another one time per month.
12. A *qualified individual* or member 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.

13. A *qualified individual* or dependent is a victim of domestic abuse or spousal abandonment and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment.
14. 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.
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 *qualified health plan* through the Health Insurance Marketplace following termination of Health Insurance Marketplace 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* newly gains access to an employer sponsor individual HRA or a Qualified Small Employer Health Reimbursement Arrangement (HRA).
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 projected to be at or below 150 percent of the federal poverty level.
18. A *qualified individual* who was previously ineligible for advance payments of the premium tax credit solely because of a household income below 100 percent of the FPL and who, during the same timeframe, was ineligible for Medicaid because he or she was living in a non-Medicaid expansion state, who either experiences a change in household income or moves to a different state resulting in the *qualified individual* becoming newly eligible for advance payments of the premium tax credit.
19. At the option of the Exchange, the *qualified individual*, or his or her dependent:
    a. Experiences a decrease in household income;
    b. Is newly determined eligible by the Exchange for advance payments of the premium tax credit; and
    c. Had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for one or more days during the 60 calendar days preceding the date of the financial change.

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

1. The *qualified individual* has not been determined eligible for *advance premium tax credits* or *cost sharing reductions*; or
2. The *qualified individual* pays the entire premium for the first partial month of coverage as well as all *cost sharing*, thereby waiving the benefit of *advance premium tax credits* and *cost sharing* reduction payments until the first of the next month.

Prior Coverage

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

hospital has concluded. Transfers from one *inpatient hospital* to another shall not be considered a discharge.

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

PREMIUMS

Premium Payment

Each premium is to be paid on or before its due date. The initial premium must be paid prior to the coverage *effective date*, although an extension may be provided during the annual open enrollment period. Ambetter reserves the right to apply any rewards that may be converted to monetary value earned through My Health Pays or any similar program to any unpaid premium or related amounts you may owe.

Grace Period

When a *member* is receiving a premium subsidy:

After the first premium is paid, A grace period of 3 months from the premium due date is given for the payment. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if *advance premium tax credits* are received.

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

When a member is not receiving a premium subsidy:

A grace period of 60 calendar days will be granted for the payment of each premium due after the first premium. During the grace period, the *policy* continues in force.

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. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *policy* will stay in force; however, claims may pend for *covered services* rendered to the member during the grace period. We will notify HHS, as necessary, of the non-payment of premiums, the member, as well as *providers* of the possibility of denied claims when the member is in the grace period.

Third-Party Payment of Premiums or Cost Sharing

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

1. Ryan White HIV/AIDS program under Title XXVI of the Public Health Service Act;
2. Indian tribes, tribal organizations, or urban Indian organizations;

3. State and federal government programs;
4. Certain tax-exempt organizations;
5. An employer for an employee under an Individual Coverage Health Reimbursement Account (ICHRA) or Qualified Small Employer Health Reimbursement Account (QSEHRA) plan;
6. Family members;
7. Private, not-for-profit foundations which have no incentive for financial gain, no financial relationship, or affiliation with *providers* of *covered services* and supplies on behalf of *members*, where eligibility is determined based on defined criteria without regard to health status and where payments are made in advance for a coverage period from the *effective date* of eligibility through the remainder of the *calendar year*.

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

Misstatement of Age

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

Change or Misstatement of Residence

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

Misstatement of Tobacco or Nicotine Use

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

PRIOR AUTHORIZATION

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

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

Prior Authorization Required

Some *covered service expenses* (medical and *behavioral health*) require *prior authorization*. In general, *non-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 in the *Schedule of Benefits*, you must obtain *authorization* from us before you or your *dependent member*:

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

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

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

1. At least 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 an admission for *inpatient* mental health or *substance use disorder* treatment.
5. At least five calendar days prior to the start of *home health care*.

After *prior authorization* is received, we will notify you and your *provider* of our decision as required by *applicable law.*

1. For urgent concurrent reviews received at least 24 hours prior to the expiration of a previously approved course of treatment, within 24 hours of receipt of the request. For all other urgent concurrent reviews, within 72 hours of receipt of the request.
2. For urgent pre-service reviews, within 72 hours receipt of the request.
3. For non-urgent pre-service reviews within 7 calendar days of receipt of the request.
4. For post-service or *retrospective reviews*, within 30 calendar days of receipt of the request.

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

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. All *medical practitioners*, 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 services that require *prior authorization*, refer to the *Schedule of Benefits* or contact Member Services. 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 the *emergency services*.

Prior Authorization Does Not Guarantee Benefits

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

Requests for Predeterminations

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

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

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

Services from Non-Network Providers

Except when *balance billing protections* apply to a *covered service* provided by a *non-network provider*, we do not normally cover services received from *non-network providers*. If a situation arises

where a *covered service* cannot be obtained from a *network provider* located within a reasonable distance, we may provide *prior authorization* for you to obtain services from a *non-network provider* at no greater cost to you than if you went to a *network provider*. If *covered services* are not available from a *network provider*, you or your *PCP* must request *prior authorization* from us before you may receive services from a *non-network provider*. Otherwise, you will be responsible for all charges incurred.

COST SHARING FEATURES

Cost Sharing Features

We will pay *benefits* for *covered services* as described in the *Schedule of Benefits* and the Major Medical Expense Benefits 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 healthcare services by paying *deductible amounts*, copa*yments* and coinsurance for some *covered services*. For example, you may need to pay a copay*ment* or *coinsurance amount* when you visit your *physician* or are admitted into the *hospital*. The copay*ment* or *coinsurance* required for each type of service as well as your *deductible* is listed in your *Schedule of Benefits*. Every benefit payment to your *provider*, including your cost-sharing amount, should be accepted as the full payment.

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

Deductible

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

Copayments

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

Coinsurance Percentage

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

When the *annual out-of-pocket maximum* has been met, additional *covered service expenses* will be provided or payable at 100 percent of the allowable expense.

The amount provided or payable will be subject to:

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

Refer to your *Schedule of Benefits* for Coinsurance percentage and other limitations.

The amount provided or payable will be subject to:

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

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

Non-Network Liability and Balance Billing

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

When receiving care at an Ambetter *network* facility, it is possible that some hospital-based *providers* (for example, assistant surgeons, hospitalists, and intensivists) may not be under contract with Ambetter 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 Ambetter.

As a member of Ambetter, *non-network providers* should not bill you for *covered services* for any amount greater than your applicable in-network *cost sharing* responsibilities when:

1. You receive a covered emergency service or air ambulance service from a *non-network provider.* This includes services you may get after you are in stable condition, unless the *non-network provider* obtains your written consent.
2. You receive non-emergency ancillary services (emergency medicine, anesthesiology, pathology, radiology, and neonatology, as well as diagnostic services (including radiology and laboratory services)) from a *non-network provider* at a *network hospital* or *network* ambulatory surgical facility.
3. You receive other non-emergency services from a *non-network provider* at a *network hospital* or *network ambulatory surgical facility*, unless the *non-network provider* obtains your written consent.

Estimate for Eligible Expenses

Upon request, we will provide you with a written statement that includes a good faith estimate of the dollar amount of the allowable benefit for a service or procedure if the request includes information regarding any service or procedure to be performed by a *non-network provider*, including any service or procedure code number or diagnosis related group provided by the health care provider and the health care *provider's* estimated charge. The written statement will be provided to you within 10 business days from the receipt of your request.

ACCESS TO CARE

Primary Care Physician

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

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

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

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

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

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

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

Contacting Your Primary Care Physician

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

Should you need care outside of your *PCP's* office hours, you should call your *PCP's* office for information on receiving after hours care in your area. If you have an urgent medical problem or question or cannot reach your *PCP* during normal office hours, call our 24/7 nurse advice line at 1-833-890-0329 (TTY 711). A licensed nurse is always available and ready to answer your health questions. If you are experiencing an *emergency condition*, call 911 or for a *behavioral health emergency condition*, call 988 or go to the nearest emergency room.

Changing Your Primary Care Physician (PCP)

You may change your *network PCP* for any reason, but not more frequently than once a month, by submitting a written request, online at our website at AmbetterHealth.com/en/NE, 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.

Referral Required for Maximum Benefits

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

Network Availability

The *network* is subject to change. The most current *network* may be found online at our website or by contacting us at the number shown on your member identification card. A *network service area* 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**: that covered services from *non-network providers* are not *covered services* under this agreement, except when *balance billing protections* apply to a *covered service* provided by a *non-network provider*. If you receive non-emergency services from *non-network providers*, that are not subject to *balance billing protections*, *benefits* will be calculated in accordance with the terms of this policy for *non-network providers*.

Coverage Under Other Policy Provisions

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

Non-Emergency Services

If you are traveling outside of the Nebraska *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 Nebraska by searching the relevant state in our provider directory at guide.AmbetterHealth.com. Not all states have Ambetter plans. If you intend to seek care from an

Ambetter *provider* outside of the *service area*, you may be required to obtain a referral from your *primary care physician* and/or *prior authorization* from the originating Ambetter state for non-emergency services. Contact Member Services at the phone number on your member identification card for further information.

Emergency Services Outside of Service Area

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

If you are temporarily out of the *service area* and experience an *emergency condition*, call 911 or for a *behavioral health emergency condition*, call 988 or go the nearest emergency room. Be sure to a call us and report your emergency within one business day. You do not need prior approval for *emergency services.*

Continuity of Care

Under the No Surprises Act, if a member is receiving a *covered service* with respect to an *network provider* or facility and: (1) the contractual relationship with the *provider* or facility is terminated, such that the *provider* or facility is no longer in the *network*; or (2) *benefits* are terminated because of a change in the terms of the participation of the *provider* or facility, as it pertains to the benefit the member is receiving, then we will:

1. Notify each *member* who is a *continuing care patient* on a timely basis of the termination and their right to elect continued transitional care from the *provider* or facility;
2. Provide the individual with an opportunity to notify the health plan of the individual's need for transitional care; and
3. Permit the individual to elect to continue to have their *benefits* for the course of treatment relating to the individual's status as a *continuing care patient* during the period beginning on the date on which the above notice is provided and ending on the earlier of:
    a. The 90 calendar day period beginning on such date; or the
    b. Date on which such individual is no longer a *continuing care patient* with respect to their *provider* or facility.

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*.

Hospital Based Providers

When receiving care at an Ambetter *network hospital* it is possible that some hospital-based *providers* (for example, assistant surgeons, hospitalists, and intensivists) may not be under contract with Ambetter as participating *providers*. If appropriate notice is provided to and acknowledged by you before rendering services, you may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by Ambetter – this is known as “balance billing”. We encourage you to inquire about the *providers* who will be treating you before you begin your treatment, so you can understand their participation status with Ambetter. Any amount you are obligated to pay to the nonparticipating *provider* in excess of the *eligible expense* will not apply to your *deductible amount* or *maximum out-of-pocket*.

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

MAJOR MEDICAL EXPENSE BENEFITS

Essential health *benefit*s 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 service expenses incurred for *medically necessary* treatment of an *acquired brain injury* will be determined on the same basis as treatment for any other physical condition. Cognitive *rehabilitation therapy*, cognitive communication therapy, neurocognitive therapy and *rehabilitation;* neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment; neurofeedback therapy, remediation required for and related to treatment of an *acquired brain injury*, post-acute transition services and community reintegration services, including outpatient day treatment services, or any other post-acute treatment services are covered, if such services are necessary as a result of, and related to, an *acquired brain injury*.

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

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

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

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

Ambulance Service Benefits

Air Ambulance Service Benefits

Covered services expenses will include ambulance services for ground, water, transportation by fixed wing and rotary wing air ambulance transportation from home, scene of accident, or medical emergency:

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

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

Prior authorization is not required for emergency air ambulance transportation. Please **NOTE**: You should not be *balance billed* for services from a *non-network* air ambulance *provider*, beyond your cost share, for air ambulance services.

Limitations: *Benefits* for air ambulance services are limited to:

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

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

Exclusions:

No *benefits* will be paid for:

1. Expenses incurred for air ambulance services covered and paid by a local governmental or municipal body, unless otherwise required by law;
2. Non-emergency ambulance services;
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 transportation (for example, commercial flights).

Ground and Water Ambulance Service Benefits

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

1. In cases where the member is experiencing an *emergency condition*, to the nearest *hospital* that can provide *emergency services* appropriate to treat the *member's emergency condition*;
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, injuries, congenital birth defects, or complications of premature birth that require that level of care;

3. Transportation between *hospitals* or between a *hospital* and skilled nursing or *rehabilitation facility* when *authorized* by Ambetter;
4. When ordered by an employer, school, fire or public safety official and the member is not in a position to refuse; or
5. When a member is required by us to move from a *non-network provider* to a *network provider*.

Prior authorization is not required for emergency ambulance transportation. **NOTE:** non-emergency ambulance transportation requires *prior authorization*.

NOTE: Unless otherwise required by federal or Nebraska law, if you receive services from non-network ambulance providers, you may be *balance billed*.

Exclusions:

No *benefits* will be paid for:

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

Autism Spectrum Disorder Benefits

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

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

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

Care Management Programs

We understand special health needs and are prepared to help you manage any that you may have. Our *care management* services can help with complex medical or *behavioral health* needs. If you qualify for *care management*, we will partner you with a care manager. Care managers are 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 Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition,
2. Reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial; and
3. All items and services that are otherwise generally available to a *qualified individual* that are provided in the clinical trial except:
    a. The investigational item or service itself;
    b. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
    c. Items and services customarily provided by the research sponsors free of charge for any *member* in the trial.

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

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

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

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

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

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

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

Participation in clinical trials is subject to *prior authorizatio*n requirements as outlined in this *policy*.

Diabetic Care

Benefits are available for *medically necessary* services and supplies used in the treatment of persons with gestational, type 1 or type II diabetes. *Covered service expenses* include, but are not limited to:

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

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

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

Dialysis Services

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

Covered expenses include:

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

After you receive appropriate training at a dialysis facility we designate, we also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis. Coverage is limited to

the standard item of equipment or supplies that adequately meets your medical needs. We will determine if equipment is made available on a rental or purchase basis. At our option, we may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a *provider* we authorize before the purchase.

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

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

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

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

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

Benefits for repairs and replacement do not include the following:

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

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

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

Disposable Medical Supplies

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

Durable Medical Equipment

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

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

1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for IV fluids and medicine.
5. Glucometer.
6. Tracheotomy tube.
7. Cardiac, neonatal, and sleep apnea monitors.
8. Augmentative communication devices are covered when we approve based on the *member's* condition.
9. Rental of one Continuous Passive Motion (CPM) machine per member following a covered joint *surgery*.
10. Rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
11. *Medically necessary* foot orthotics.
12. Hearing aid coverage on a continual basis to the extent that *benefits* paid for such items and services during the immediately preceding 48 month period have not exceeded $3000. Coverage includes the following:
    a. A hearing aid purchased from a licensed audiologist with the medical clearance from an otolaryngologist and costs related to dispensing such hearing aid;
    b. Evaluation for a hearing aid;
    c. Fitting of a hearing aid;
    d. Programming of a hearing aid;
    e. Probe microphone measurements for verification that hearing aid gain and output meet the prescribed targets;
    f. Hearing aid repairs;
    g. Follow-up adjustments, servicing, and maintenance of a hearing aid;
    h. Ear mold impressions;
    i. Ear molds;

j. Auditory *rehabilitation* and training; and

k. Replacement of hearing aids as prescription changes.

Exclusions:

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

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

DME equipment and supplies are subject to *prior authorization* as outlined in this *policy*.

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

Medical and Surgical Supplies

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

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

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

Exclusions:

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

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

Orthotic Devices

Covered services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of

movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage, and handling charges are also covered. The casting is covered when an *orthotic device* is billed with it, but not if billed separately.

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

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

Orthotic devices may be replaced once per year per member when *medically necessary* in the *member's* situation. However, additional replacements will be allowed for *members* when *medically necessary*, or for any member when a 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 and corrective shoes, unless they are an integral part of a leg brace;
2. Garter belts, and other supplies not specifically made and fitted (except as specified under the Medical and Surgical Supplies provision).

Prosthetics

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

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

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

Covered Services may include, but are not limited to:

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

Exclusions:

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

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

Emergency Services

If you experience an *emergency conditio*n, you should call 911 or for a behavioral health emergency condition, call 988 or go to the nearest emergency room. We cover *emergency services* both in and out of our *service area*. We cover these services 24 hours a day, 7 days a week.

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

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* include the following for adolescent and adult women, in accordance with the most recent guidelines supported by Health Resources and Services Administration (HRSA):

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

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

Fertility Preservation

Medically necessary services and supplies for standard fertility preservation treatments are covered when a cancer treatment may directly or indirectly cause iatrogenic infertility. Iatrogenic infertility is infertility that is caused by a medical intervention, including reactions from prescribed drugs or from

medical or surgical procedures that may be provided for cancer treatment. Prior authorization may be required.

Habilitation, Rehabilitation, and Extended Care Facility Expense Benefits

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

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

Cardiac *rehabilitation* is a *covered service* that is unlimited; however, it excludes cardiac *rehabilitation* services provided on a non-monitored basis and treatment for mental disabilities.

Prior authorization may be required as outlined in this *policy*. See the *Schedule of Benefits* for benefit levels or additional limits.

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

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

Home Health Care Service Expense Benefits

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

1. *Home health aide services*;
2. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to your *Schedule of Benefits* for any limits associated with this *benefit*;
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care*;

4. Intravenous medication and pain medication;
5. Hemodialysis, and for the processing and administration of blood or blood components;
6. *Necessary medical supplies*;
7. Rental of *medically necessary durable medical equipment*.

Charges under (4) are *covered service* expenses to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

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.

Limitations:

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

Exclusion:

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

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

Hospice Care Service Expense Benefits

Hospice care *benefits* are allowable for a *terminally ill* member receiving *medically necessary* care under a *hospice* care program or in a home setting. *Covered services* and supplies include:

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

Benefits for *hospice inpatient*, home and outpatient care are available for five days per episode.

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 provision.

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

Respite Care Expense Benefits

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

Hospital Benefits

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

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

Long Term Acute Care (LTACH)

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

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

1. Complex wound care:
    a. Daily *physician* monitoring of wound.
    b. Wound requiring frequent complicated dressing changes, and possible repeated.
    c. Debridement of necrotic tissue.
    d. Large wound with possible delayed closure, draining, and/or tunneling or high output.
    e. Fistulas.
    f. Lower extremity wound with severe ischemia.
    g. 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 percent or less with O2 saturation at least 90 percent.
   g. Common conditions include complications of acute lung *injury*, disorders of the central nervous and neuromuscular systems, and cardiovascular, respiratory, and pleural/chest wall disorders.
   h. Patient continues to meet the criteria above and does not meet the criteria to be transitioned to alternate level of care.

Lymphedema Benefit

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

Mammography Coverage

Covered services for a *member* will include mammography screenings that align with USPSTF A and B rated guidelines, as well as *applicable laws*. This coverage includes *medically necessary* preventive and diagnostic mammograms, digital breast tomosynthesis, magnetic resonance imaging (MRI) and ultrasound examinations, and pathology evaluations. Coverage is available to all *members*,

regardless of age, when these services are prescribed by a licensed *medical practitioner* working within the scope of their license. For further details on this benefit, please refer to the Preventive Care Guide.

Maternity Care

Coverage for outpatient and *inpatient* pre- and post-partum care including examinations, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and *hospital* stays for delivery or other *medically necessary* reasons (less any applicable *copayments*, *deductible amounts*, or coinsurance). An *inpatient* stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a cesarean delivery. An *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require notification to us. Other maternity *benefits* include *complications of pregnancy*, parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests. Coverage will only be provided for maternity services or care of the newborn child when such services have been *authorized* by your participating health care provider.

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

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

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

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

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

Newborn Charges

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

Duty to Cooperate

We do not cover services or supplies related to a *member's pregnancy* when a *member* is acting as a *surrogate* and has entered into a *surrogacy arrangement*. For more information on excluded services,

please see the General Non-Covered services and Exclusions section. *Members* who are a *surrogate* at the time of enrollment or *members* who agree to a *surrogacy arrangement* during the plan year must, within 30 calendar days of enrollment or agreement to participate in a *surrogacy arrangement*, send us written notice of the *surrogacy arrangement* to:

Ambetter Health
Attention: Member Services
2525 N. 117th Avenue, Ste. 100,
Omaha, NE 68164.

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.

Newborns' and Mothers' Health Protection Act Statement of Rights

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

Medical and Surgical Expense Benefits

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

1. For *surgery* in a *physician's* office, an *inpatient* facility, outpatient facility or a surgical facility, including services and supplies.
2. For pre-surgical and post-surgical procedures and testing, including but not limited to, diagnostic services using radiologic, ultrasonographic or laboratory services:
    a. Laboratory tests or radiological examinations done on an outpatient basis in a *hospital* or other facility accepted by the *hospital* before *hospital* confinement or outpatient *surgery* or procedures. The tests must be for the same bodily *illness* or *injury* causing the *member* to be *hospitalized* or to have the outpatient *surgery* or procedure.
    b. Bone density studies.
    c. Clinical laboratory tests.
    d. Gastrointestinal laboratory procedures.
    e. Pulmonary function tests.
    f. Genetic testing.
    g. For *medically necessary* genetic or molecular cancer testing, including but not limited to, tumor mutation testing, next generation sequencing, hereditary germline mutation testing, pharmacogenomics testing, whole exome, genome sequencing and biomarker testing.
3. For medical services in an office or facility that is provided by a licensed *medical practitioner* or *specialist physician*, including consultations and *surgery* related services.
4. For elective sterilization procedures (i.e., vasectomies). **NOTE**: No cost-share applies, except on HSA-compatible plans.

5. For chemotherapy (including oral chemotherapy), inhalation therapy, infusion therapy, and radiation therapy or treatment in a *hospital* or office setting.
6. For *durable medical equipment*, *prosthetic devices*, *orthotic device*s or other *necessary medical supplies* following a medical or *surgical procedure* such as crutches, orthopedic splints, braces or casts. Please see the *Durable Medical Equipment* provision of this *policy*.
7. For hemodialysis and the charges by a *hospital* or facility for the processing and administration of genetic testing, blood or blood components, including cost of blood, blood plasma and blood plasma expanders, which is not replaced by or for you.
8. For the cost and administration of anesthesia, oxygen, drugs, medications and biologicals.
9. For *medically necessary* reconstructive or cosmetic *surgery* including, but not limited to:
    a. *Reconstructive surgery* for craniofacial abnormalities.
10. For *medically necessary* dental *surgery* due to:
    a. An accidental *injury* which results in damage to natural teeth. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
    b. *Surgery* to correct a functional defect which results from a congenital and/or acquired disease or anomaly.
    c. Cleft lip and cleft palate for an eligible member. *Covered services* include medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the treating *physician* or surgeon and such *physician* or surgeon certifies that such services are *medically necessary* and consequent to treatment of the cleft lip or cleft palate.
    d. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* charges for dental care, rendered by a dentist, provided to the following *members*:
        i. A member whose treating *medical practitioner* in consultation with the dentist, determines the member has a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or
        ii. A member who has one or more medical conditions that would create significant or undue medical risk for the member during delivery of any dental treatment or *surgery* if not rendered in a *hospital* or ambulatory surgical facility.
        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 facility 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 facility.
11. For infertility counseling and planning services when provided by a *network provider* and testing to diagnose infertility.
12. For the treatment of breast cancer by dose-intensive chemotherapy *bone marrow transplant*s or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy *bone marrow transplants* or stem cell transplants.
13. For routine patient care for *members* enrolled in an eligible cancer clinical trial that is deemed an *experimental or investigational* treatment if the services provided are otherwise considered *covered services* under this *policy*. See the Clinical Trial Coverage provision of this *policy*.

14. For the following types of *medically necessary* implants and tissue grafts:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.
    e. Implantable prosthetic lenses, in connection with cataracts.
    f. Skin grafts.
15. For X-rays, Magnetic Resonance Imaging (MRI), Computed Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT), and other diagnostic services. See Radiology, Imaging and Other Diagnostic Testing provision of this *policy*.
16. For *medically necessary telehealth services*. *Telehealth services* not provided through *Virtual 24/7 Care* would be subject to the same *cost sharing* as the same health care services when delivered to a member in person.
17. For *surgery* or services related to cochlear implants and bone-anchored hearing aids.
18. For *medically necessary* services for complications arising from medical and surgical conditions.
19. For respiratory, pulmonary, cardiac, physical, occupational and speech therapy services. Please see Rehabilitation and Extended Care Facility Expense Benefits and Habilitation Expense Benefits provisions of this *policy*.
20. For children's early intervention therapy for expenses arising from the services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists and clinical social workers working with children from birth to 36 months of age with an identified developmental disability and/or delay.
21. For *medically necessary* footcare treatment that may require *surgery*; *prior authorization* may be required.
22. For dermatology services which are limited to the following: *medically necessary* minor *surgery*, tests and office visits provided by a dermatologist who is a *network provider*.
23. For *medically necessary* biofeedback services.
24. For abortions unless performed to save the life the *member*, consistent with the appropriate determination of the physician, and not illegal under applicable law.
25. For services associated with human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in *bone marrow transplantation* or transplant procedures.
26. For 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.
27. For *medically necessary chiropractic care* treatment on an outpatient basis only. See the *Schedule of Benefits* for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *policy*, including the d*eductible amount* and *cost sharing* provisions.

28. For all *medically necessary* immunizations, monitoring, screenings, re-screenings and laboratory testing for a newborn in the early detection, diagnosis and intervention of a condition or disorder. This also includes, but not limited to, hearing or audiological services, follow-up examinations and pulse oximetry.
29. For *medically necessary* allergy testing and treatment including allergy injections and serum.
30. Testing of pregnant women and other *members* for lead poisoning.
31. Services related to diagnosis, treatment, and appropriate management of osteoporosis when such services are provided by a person licensed to practice medicine and *surgery* in the state, if the *member* has a condition or medical history for which bone mass measurement is medically indicated.

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

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

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

Medical Dental Services

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

1. Coverage is also provided for:
    a. For *medically necessary* oral *surgery*, including the following:
    b. Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
    c. 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.
    d. Oral/surgical correction of accidental injuries.
    e. Treatment for Temporomandibular Joint Disorder (TMJ), including removable appliances for TMJ repositioning and related *surgery*, medical care, and diagnostic services.
    f. Treatment of non-dental lesions, such as removal of tumors and biopsies.
    g. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

h. *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.

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

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

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

Medical Foods

We cover medical foods and formulas for:

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

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

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

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

Low-Protein Food Products for Treating Inherited Metabolic Diseases

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

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

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

Nutritional Counseling

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

Medical Vision Services

Covered services include vision screenings to diagnose and treat a suspected disease or *injury* of the eye.

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

1. Referrals to a specialist 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.

Our *behavioral health* and *substance use disorder* vendor oversees the delivery and oversight of covered *behavioral health* and *substance use disorder* services for Ambetter. If you need mental health or *substance use disorder* treatment, you may choose any provider participating in our mental health *network* and do not need a referral from your *PCP* in order to initiate treatment. You can search for *network* mental health providers by accessing our "Find a Doctor" page at AmbetterHealth.com/en/NE 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*.

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

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 disorder*;
5. *Inpatient* Psychiatric Hospitalization; and
6. Electroconvulsive Therapy (ECT).

Outpatient

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

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* or residential *substance use disorder* treatment services. Please see your *Schedule of Benefits* for more information regarding services that require *prior authorization.*

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

Pediatric Vision Expense Benefits – Children under the age of 19

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

1. Routine ophthalmological examination;
    a. Refraction.
    b. Dilation.
2. Standard frames;
3. Prescription lenses;
    a. Single.
    b. Bifocal.
    c. Trifocal.
    d. Lenticular.
    e. Contact lenses (in lieu of glasses).
4. Additional lens options (including coating and tints);
    a. Progressive lenses (standard or premium).
    b. Intermediate vision lenses.
    c. Blended segment lenses.
    d. Hi-Index lenses.
    e. Plastic photosensitive lenses.
    f. Photochromic glass lenses.
    g. Glass-grey #3 prescription sunglass lenses.
    h. Fashion and gradient tinting.
    i. Ultraviolet protective coating.
    j. Polarized lenses.
    k. Scratch resistant coating.
    l. Anti-reflective coating (standard, premium or ultra).
    m. Oversized lenses.
    n. Polycarbonate lenses.
5. Contact lenses and contact lens fitting (in lieu of eyeglasses).

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 AmbetterHealth.com/en/NE or call Member Services.

Covered service expenses do not include:

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

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

Prescription Drug Expense Benefits

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

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

1. A *prescription drug*;
2. Any drug that, under the applicable law, may be dispensed only upon the written prescription of a provider;
3. Epinephrine Injectors: The total amount you are required to pay for a twin pack of epinephrine injector will not exceed amount set by applicable state or federal law;
4. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one (1) standard reference compendium; or
    b. Recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain; and
    c. Recommended to treat human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS);
5. Prescribed, oral anticancer medication.

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

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.

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

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

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

Non-Formulary Prescription Drugs

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

Over the Counter (OTC) Prescriptions

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

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 AmbetterHealth.com/en/NE 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 AmbetterHealth.com/en/NE. You can also request to have a copy mailed directly to you.

Mail Order Pharmacy/Prescription Drug Delivery

Mail order pharmacy offers a convenient way to receive your prescriptions. Eligible prescriptions will be safely delivered right to your door at no extra charge to you. You will still be responsible for your regular *copayment/coinsurance*. To enroll for mail order delivery or for any additional questions,

please refer to our Ambetter website. Once on our Ambetter website, you will find details on your in-network mail order pharmacies and next steps for enrollment.

Medication Balance-on-Hand

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

Split-Fill Dispensing Program

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

Lock-In Program

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

Extended Days' Supply

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

Manufacturer Coupons and Other Assistance

Any amount paid by you or on your behalf by *third parties* and drug manufacturer coupons, are included in your *deductible* and maximum-out-of-pocket calculations.

Prescription Drug Exception Process

Standard exception request

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

Expedited exception request

A *membe*r, a *member's authorized representative* or a *member's* prescribing *physicia*n may request an expedited review based on exigent circumstances. Exigent circumstances exist when a member is suffering from a health condition that may seriously jeopardize the *member's* life, health, or ability to

regain maximum function or when an *member* is undergoing a current course of treatment using a non-formulary drug. The request can be made in writing or via telephone. Within 24 hours of the request being received, we will provide the member, the *member's authorized representative* or the *member's* prescribing *physician* with our coverage determination. Should the standard exception or step therapy protocol exception request be granted, we will provide coverage of the non-formulary drug or the drug that is the subject of the protocol exception for the duration of the exigency.

External exception request review

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

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

Non-Covered Services and Exclusions:

No *benefits* will be paid under this benefit provision for services provided or expenses incurred:

1. For *prescription drug* treatment of erectile dysfunction or any enhancement of sexual performance unless such treatment is listed on the formulary.
2. For weight loss *prescription drugs* unless otherwise listed on the formulary.
3. For immunization agents, blood, or blood plasma, except when used for preventive care and listed on the formulary.
4. For medication that is to be taken by the member, in whole or in part, at the place where it is dispensed.
5. For medication received while the member is a patient at an institution that has a facility for dispensing pharmaceuticals.
6. For a refill dispensed more than 12 months from the date of a *physician's* order.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are listed on the formulary.
9. For drugs labeled "Caution – limited by federal law to investigational use" or for investigational or experimental drugs.
10. For any drug that we identify as therapeutic duplication through the Drug Utilization review program.

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

Preventive Care Expense Benefits

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

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).

2. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
4. With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA , to the extent the care is not illegal under *applicable law*.

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

Preventive care refers to services or measures taken to promote health and early detection or prevention of diseases and injuries, rather than treating or curing them. Preventive care includes, but is not limited to, immunizations, medications, *tobacco* cessation treatment, examinations and screening tests (e.g., colorectal cancer screenings) 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. For HSA-compatible plans, the deductible cannot be waived for benefits that exceed the federal ACA preventive care requirements.

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 law*.

Our Ambetter Health Preventive Care Guide is updated annually and contains detailed information regarding preventive care coverage available to you. It is accessible via our website. To request a paper copy, please contact Member Services for assistance.

Covered services include colorectal cancer tests for *members*, in accordance with the current American Cancer Society guidelines. *Covered services* may include one or more of the following with no *cost share*:

1. Removal of tissue or other matter;
2. Laboratory services;
3. Physician services;
4. Facility use; and
5. Anesthesia.

Polyp removal performed during the screening procedure:

1. Any pathology examination on a polyp biopsy performed as part of the screening procedure;
2. Required specialist consultation prior to the screening procedure;
3. Bowel preparation medications prescribed for the screening procedure; and
4. Anesthesia services performed in connection with a preventative colonoscopy.

Notification

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

Prostate Specific Antigen Testing

Medically necessary, *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.

Coverage is available to all members, regardless of age, when these services are rendered by a medical practitioner.

Radiology, Imaging and Other Diagnostic Testing

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

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

Second Medical Opinion

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

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

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

obtained for a second medical opinion from a *non-network provider*, you will be responsible for the related expenses and you may be *balance billed* for services received.

Sleep Studies

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

Transplant Expense Benefits

Covered Services For Transplant Service Expenses:

Transplants are a *covered service* when a member is accepted as a transplant candidate and pre-authorized in accordance with this *policy*. *Prior authorization* must be obtained through the "*Center of Excellence*", a network facility, or in a non-network facility approved by us when there is no network adequacy, 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, 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 *members 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 the *member* and donor are an appropriate candidates for a *medically necessary* transplant, live donation, *covered service expenses* will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting of the organ from the donor.
3. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
4. Including outpatient *covered services* related to the transplant *surgery*, pre- transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection, and other immunosuppressive drug therapy, etc.
5. Pre-transplant stabilization, means an *inpatient* stay to medically stabilize the recipient to prepare for a later transplant, whether or not the transplant occurs.
6. The transplant itself, including the acquisition cost for the organ or bone marrow when *authorized* through the *Center of Excellence* and services are performed at participating facility.
7. Post-transplant follow-up visits and treatments.

8. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.

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. AmbetterHealth.com/en/NE

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

Ancillary "*Center of Excellence*" Service Benefits:

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

1. We will pay for the following services when the *member* is required to travel more than 60 miles from the *residence* to the *Center of Excellence:*
2. We will pay a maximum of $10,000 per transplant service for the following services:
    a. Transportation for the *member*, any live donor, and the companion(s) to accompany to and from the *Center of Excellence*, in the United States.
    b. When a *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 or companion(s) accompanying the *member* while the *member* is confined in the *Center of Excellence* in the United States. We will reimburse *members* for the proof of costs directly related for transportation, lodging and any of the following approved items listed in the member transplant reimbursement guidelines. However, you must make the arrangements and provide the necessary paid receipts for reimbursement within 6 months of the date of service in order to be reimbursed.

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

Non-Covered services and Exclusions:

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

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the *Center of Excellence*.

4. To keep a donor alive for the transplant operation, except when *authorized* through the *Center of Excellence*.
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
6. Related to transplants unauthorized though the *Center of Excellence* and is not included under this provision as a transplant.
7. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (FDA) regulation, regardless of whether the trial is subject to FDA oversight.
8. The acquisition cost for the organ or bone marrow, when provided at an unauthorized facility or not obtained through the *Center of Excellence*.
9. For any transplant services and/or travel related expenses for *member* and donor, when performed outside of the United States.
10. The following ancillary items listed below, will not be subject to member reimbursement under this *policy*:
    a. Alcohol/*tobacco*
    b. Car, trailer or truck rental (unless pre-approved by Case Management)
    c. Vehicle maintenance for motorized and hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.).
    d. Parking (unless 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. For any services related to pet care, boarding, lodging, food, and/or travel expenses.
    l. Expenses for persons other than the transplant recipient, donor or their respective companion(s).
    m. Expenses for lodging when the transplant recipient, donor, or their respective companion(s) are staying with a relative, friend or otherwise have free lodging.
    n. Any expense not supported by a receipt.
    o. Upgrades to first class travel (air, bus, and train).
    p. Personal care items (e.g., shampoo, deodorant, clothes).
    q. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA pre-check, and early check-in boarding fees, extra baggage fees.
    r. Souvenirs (e.g., t-shirts, sweatshirts, toys).
    s. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type.
    t. All other items not described in the *policy* as *eligible expenses.*

u. Any fuel costs 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 an in-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 an *urgent care center.*

Members are encouraged to contact their *PCP* for an appointment before seeking care from another *provider,* but *network urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *PCP* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-833-890-0329 (TTY 711). The 24/7 Nurse Advice Line is available twenty-four (24) hours a day, seven (7) days a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

WELLNESS PROGRAMS AND OTHER OFFERINGS

In connection with this *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/en/NE 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, including those that may be converted to monetary value, 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. Ambetter reserves the right to apply any such rewards to any unpaid premium or related amounts you may owe.

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 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 Perks program for paying their d*eductibles*, *copayments*, and *coinsurance* on *covered services*, with several repayment options to fit their needs. The Ambetter Perks program is offered to all *members*. We are not involved in administering programs; you will communicate directly with any vendors if you choose to participate.

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No *benefits* will be provided or paid for:

1. Any service or supply that would be provided without cost to the member in the absence of insurance covering the charge.
2. Expenses, fees, taxes, or surcharges imposed on the member by a *provider* (including a *hospital*) but that are actually the responsibility of the *provider* to pay.
3. Any services performed by a member of the *member's immediate family*.
4. Any services not identified and included as *covered service* expenses under the *policy*. You will be fully responsible for payment for any services that are not *covered service expenses*.
5. Any services where other coverage is primary to Ambetter must be first paid by the primary payor prior to consideration for coverage under Ambetter.
6. For 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 service expenses will not include, and no *benefits* will be provided or paid for any charges that are incurred:

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *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* and weight loss programs, except as specifically covered in the Major Medical Expense Benefits section of the *policy*.
4. For the reversal of elective sterilization.
5. For abortion unless performed to save the life of the member, consistent with the appropriate determination of the physician, and not illegal under applicable law.
6. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Major Medical Expense Benefits provision.
7. For expenses for television, telephone, or expenses for other persons.
8. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
9. For telephone consultations between *providers*, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
10. For telephone consultations or for failure to keep a scheduled appointment.
11. For stand-by availability of a *medical practitioner* when no treatment is rendered.

12. For dental service expenses, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits.
13. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect.
14. Mental health services are excluded for:
    a. School funded/administered services for psychological testing associated with the evaluation and diagnosis of learning disabilities.
    b. Pre-marital counseling.
    c. Court ordered care or testing or required as a condition of parole or probation. *Benefits* will be allowed for services that are *medically necessary* and would otherwise be covered under this *policy*.
    d. Testing of aptitude, ability, intelligence or interest; and
    e. Evaluation for the purpose of maintaining employment.
15. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
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 service*s. 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. For treatment received outside the United States, except for a medical emergency while traveling for up to a maximum of 90 consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical emergencies for the entire period of travel including the first 90 calendar days.
23. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the member is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a *member's* right to recover future medical *benefits* under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's* workers' compensation claim, this exclusion will still apply unless that denial is *appealed* to the proper governmental agency and the denial is upheld by that agency.
24. For fetal reduction *surgery*.

25. Except as specifically identified as a *covered service expense* under the *policy*, for 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 (except where required by federal or state law): artificial insemination; blood and blood products; care or complications resulting from non-covered services; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods provision; foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; 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. For 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. *Surrogacy arrangement*. For 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*. 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 *surrogate* resulting from the *pregnancy*; or

j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*.

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

34. For any medicinal and recreational use of cannabis or marijuana.
35. For expenses for services related to dry needling.
36. For expenses, services, and treatments from a Naprapathic specialists for conditions caused by contracted, injured, spasmed, bruised, and/or otherwise affected myofascial or connective tissue.
37. For expenses, services, and treatments from a Naturopathic specialists for treatment of prevention, self-healing and use of natural therapies.
38. For the treatment of infertility. **NOTE**: Coverage is available for diagnosis and services required to correct underlying medical causes of infertility.
39. For weight loss programs, gym memberships, exercise equipment, or meal preparation programs.
40. For expenses, services, and treatments and treatment of a private duty registered nurse in an *inpatient*, outpatient, or home basis.
41. For vehicle installations or modifications which may include, but are not limited to, adapted seat de-vices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.
42. 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. Nonpayment of premiums when due, subject to the Grace Period provision in this *policy*;
2. The date we receive a request from you to terminate this *policy*, or any later date stated in your request, or if you are enrolled through the Health Insurance Marketplace, the date of termination that the Health Insurance Marketplace provides us upon your request of cancellation to the Health Insurance Marketplace;
3. The date we decline to renew this *polic*y, as stated in the Discontinuance provision;
4. The date of your death, if this *policy* is an individual plan;
5. The date a *member's* eligibility for coverage under this *policy* ceases due to any of the reasons stated in the Eligibility and Enrollment section in this *policy*; or
6. The date a *member's* eligibility for coverage under this *policy* ceases as determined by the Health Insurance Marketplace.

Refund upon Cancellation

We will refund any premium paid and not earned due to *policy* termination. You may cancel the *policy* at any time by providing written notice to the entity in which you enrolled. Such cancellation shall become effective upon receipt, or on such later date specified in the notice. Upon cancellation or termination of the policy, we shall promptly return any unearned portion of the premium paid back to the original method of payment and/or payor, but in any event shall return the unearned portion of the premium within 20 calendar days. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the *effective date* of the cancellation.

Reinstatement

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

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 and refuse to renew 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* are referred to as "*third-party injuries*." "Responsible party" includes any parties actually, possibly or potentially responsible for payment of expenses associated with the care or treatment of third-party *injuries*.

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

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

By accepting *benefits* under this plan, the member specifically acknowledges Ambetter Health's right of recovery. When this plan provides health care *benefits* for expenses incurred due to *third-party* injuries, Ambetter Health 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. Ambetter Health may proceed against any party with or without the *member's* consent.

By accepting *benefits* under this plan, the member also specifically acknowledges Ambetter Health's right of reimbursement. This right of reimbursement attaches when this plan has provided health care *benefits* for expenses incurred due to *third-party* injuries and the member or the *member's* representative has recovered any amounts from any source. Ambetter Health's right of reimbursement is cumulative with and not exclusive of Ambetter Health's right of recovery and Ambetter Health 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 Ambetter Health 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 Ambetter Health 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 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 Ambetter Health, you shall be responsible for all *benefits* paid by this plan in addition to costs and attorney's fees incurred by Ambetter Health in obtaining repayment.

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

COORDINATION OF BENEFITS

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

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

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

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

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

The term "Plan" includes:

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

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

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

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

Order of Benefit Determination Rules

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

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

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

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

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

Effects of Coordination

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

Right to Receive and Release Needed Information

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

CLAIMS

Notice of Claim

We must receive notice of claim within 20 calendar days of the date the *loss* began or as soon as reasonably possible.

Claim Forms

When a request for a claim form or the notice of a claim is provided to us, we will provide the claimant the claim forms required for filing. If the claimant does not receive these claim forms within 15 calendar days after we receive the notice of claim or the request for a claim form, the claimant will be considered to meet the *proof of l*oss requirement of this *policy*.

Proof of Loss

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

How to Submit a Claim

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

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

To request reimbursement for a *covered service*, you need a copy of the detailed claim from your *provider*. You will also need to submit a copy of the member reimbursement claim form posted at AmbetterHealth.com/en/NE. Send all the documentation to us at the following address:

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

Cooperation Provision

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

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

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

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

Time for Payment of Claims

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

Payment of Claims

Except as set forth in this provision, all *benefits* are payable to you. Any accrued *benefits* unpaid at your death, or your *dependent member's* death may, at our option, be paid either to the beneficiary or to the estate. If any benefit is payable to your or your *dependent member's* estate, or to a beneficiary who is a minor or is otherwise not competent to give valid release, we may pay up to $5,000 to any relative who, in our opinion, is entitled to it.

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

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

Claims Incurred for Emergency Services While Traveling Outside of the United States

Medical *emergency services* are covered for up to 90 consecutive days while traveling outside of the United States. If travel extends beyond 90 consecutive days, no benefit coverage is provided for *emergency services* 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 within 180 calendar days from the date of service. The claims must include clinical documentation (medical records) that supports all *emergency services* received. Claims and medical records must be submitted in English or with an English translation, at the *member’s* expense to show proper *proof of loss* and evidence of any payment(s) to the *provider*. Proof of departure from and arrival to the United States must be submitted with the claim. These documents must be submitted with the Member Reimbursement Medical Claim Form, along with all requested documents as detailed on the claim form. All forms and *member* resources are available at AmbetterHealth.com/en/NE.

Reimbursement for covered *emergency services* (less the *member's* cost share responsibility) will be sent to the *member*, who is responsible for paying the provider. Such payment will fulfill our obligation

to the *member* for the *emergency services*. Reimbursement is based on the *member's* benefit plan, *cost share*, and currency exchange rate at the time of the transaction. The Explanation of Benefits will detail the *member's* responsibility and any eligible reimbursement.

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

Medicaid Reimbursement

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

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

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

Change of Beneficiary

The right to change of beneficiary is reserved to the member and the consent of the beneficiary, or beneficiaries, shall not be requisite to surrender or assignment of this *policy* or to any other changes in this *policy*.

Physical Examination and Autopsy

We shall have the right and opportunity to examine a member while a claim is pending or while a dispute over the claim is pending and to make an autopsy in case of death where it is not forbidden by law. These examinations are made at our expense and as often as we may reasonably require.

Legal Actions

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

GRIEVANCE, APPEAL, AND EXTERNAL REVIEW PROCEDURES

Grievances

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

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

1. Availability, delivery or quality of health care services;
2. Matters pertaining to the contractual relationship between a covered person and Ambetter Health;
3. Matters pertaining to the contractual relationship between a health care *provider* and Ambetter Health; and
4. Contract reformation or amendment disputes.

Filing a Grievance

Grievances may be requested by a member or *authorized representative*. *Grievances* may be filed orally by calling 1-833-890-0329 (TTY 711) or in writing by mailing us a letter or the Grievance and Appeal Form from our website to:

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

A *member or authorized representative* has the right to submit written comments, documents, records, and other information relating to the claim for *benefits*, and the right to review the claim file. However, the *member* does not have the right to attend, or to have a representative in attendance, at the *grievance* review.

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 *member*.
2. Person *authorized* to act on behalf of the *member*. **NOTE**: Written *authorization* is not required; however, if received, we will accept any written expression of *authorization* without requiring specific form, language, or format.
3. In the event the *member* is unable to give consent: a *spouse,* family member, or the treating *provider*. In the event of an *expedited grievance*: the person for whom the insured has verbally given *authorization* to represent the claimant.

NOTE: *Grievances* with respect to *adverse determinations* are referred to in this document as *appeals* and will follow the standard Patient Protection and Affordable Care Act (PPACA) internal *appeals* procedures as explained herein.

Acknowledgement

Within three business days of receipt of a *grievance*, a written acknowledgment to the member or *authorized representative* confirming receipt of the *grievance* must be delivered or deposited in the mail.

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

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

Resolution Timeframes

Ambetter Health will issue a written decision, in clear terms, to the *member* and *authorized representative*, if applicable, within 15 business days after receiving the *grievance*. Ambetter Health may extend the timeframe for disposition of a *complaint* for up to 15 business days if the *member* requests the extension or if the *member* gives consent.

Right to Participate

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

Written *Grievance* Response

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

Our written decision to the member must include:

1. The names, titles of the person or persons acting as the reviewer or reviewers participating in the *grievance* review process;
2. A statement of the reviewers' understanding of the *member's grievance*;
3. The reviewers' decision in clear terms and the *policy* basis in sufficient detail for the covered person to respond further to the health carrier's position;
4. A reference to the evidence or documentation used as the basis for the decision; and

5. Notice of the covered person's right to contact the *director's* office. The notice shall contain the telephone number and address of the *director's* office.

Appeals (Adverse Determination Grievances)

When we deny a claim for a treatment or service, or we deny the *member's* request to authorize treatment or service, our decision is known as an *adverse determination*. The member, their *provider* or *authorized representative* can request an *appeal* of our decision. If we rescind the *member's* coverage or deny the *member's* application for coverage, the member, their *provider* or *authorized representative* may also *appea*l our decision. When we receive an *appeal*, we are required to review our own decision.

Filing an Appeal

Appeals must be filed in writing by completing the Grievance and Appeals Form from our website or sending a written *appea*l along with copies of any supporting documents and mailed or faxed to:

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

Time Limits for Filing an Appeal

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

Applicability/Eligibility

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

An eligible appellant is:

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

Acknowledgement

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

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

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

Resolution Timeframes

Appeals will be resolved and we will notify the *member* in writing with the *appeal* decision within 15 business days.

Ambetter Health may seek *member's* approval to extend the time for providing a decision for 15 business days after the expiration of the initial period, or if the plan determines that such an extension is necessary for reasons beyond the control of the plan. There is no provision for extensions in the case of claims involving urgent care or expedited *appeals*.

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

1. The *member* will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The plan will give the member 10 calendar days to respond to the new information before making a determination, unless the State turnaround time for response is due in less than 10 calendar days. If the State turnaround time is less than 10 calendar days, the *member* will have the option of delaying the determination for a reasonable period of time to respond to the new information; or
2. The *member* will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer. The plan will give the member 10 calendar days to respond to the new medical rationale before making a determination, unless the State turnaround time for response is due in less than 10 calendar days. If the State turnaround time is less than 10 calendar days, the *member* will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.

Expedited Appeal

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

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

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

2. In the opinion of a *provider* with knowledge of the *member's* medical condition, the member is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *appeal.*

If the expedited *appeal* involves an *adverse determination* with respect to a concurrent review of an urgent care request, the service shall be continued until the member or *authorized representative* has been notified of the determination or until the healthcare *provider* determines that the urgent care is no longer appropriate or necessary. This does not apply to requests for extensions.

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

Simultaneous expedited appeal and external review

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

1. The member has a medical condition in which the timeframe for completion of an expedited review of the *appeal* involving an *adverse determination* would seriously jeopardize the life or health of the covered person or would jeopardize the *member's* ability to regain maximum function; or
2. The *adverse determination* involves a denial of coverage based upon a determination that the recommended or requested health care service or treatment is *experimental or investigational* and the *member's* treating *physician* certifies in writing that the recommended or requested health care service or treatment that is the subject of the *adverse determination* would be significantly less effective if not promptly initiated.

Right to Participate

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

Continuing Coverage

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

Cost and Minimums for Appeals

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

Rescission of coverage

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

Emergency medical services

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

Written Appeal Response

*Appea*l response letter (*final adverse determination*s) will be written in a manner to be understood by the member and the notification shall include the specific reasons for the denial, determination, or initiation of disenrollment.

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

1. The names, titles, and qualifying credentials of the person or persons acting as the reviewer or reviewers participating in the *appeal* review process;
2. A statement of the reviewers' understanding of the covered person's *appeal*;
3. The reviewers' decision in clear terms and the *policy* basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;
4. A reference to the evidence or documentation used as the basis for the decision;
5. The instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination;
6. Notice of the covered person's right to contact the *director's* office. The notice shall contain the telephone number and address of the director*'s* office;
7. Any corrective action taken on the *appeal*;
8. Reference to the specific plan or *policy* provision on which the determination is based;
9. A statement that the member is entitled to receive, upon request and free of charge, reasonable access to and, copies of all documents, records and other information relevant to the *member's* issue;
10. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the *adverse determination*, either the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the *adverse determination* and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the member upon request;
11. If the *adverse determination* is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the *member's* medical circumstances or a statement that such explanation will be provided free of charge upon request;
12. A description of the procedures for obtaining an external review of the *final adverse determination*; and
13. If applicable:
    a. Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse determination*;
    b. The date of service;
    c. The health care *provider's* name;

d. The claim amount;

e. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;

f. Ambetter Health's denial code with corresponding meaning;

g. A description of any standard used, if any, in denying the claim;

h. A description of the external review procedures, if applicable;

i. The right to bring a civil action under state or federal law;

j. A copy of the form that authorizes Ambetter Health to disclose protected health information, if applicable;

k. That assistance is available by contacting the Nebraska Department of Insurance, if applicable; and

l. A culturally linguistic statement based upon the *member's* county or state of *residence* that provides for oral translation of the *adverse determination*, if applicable.

Complaints received from the State Department of Insurance

The Department of Insurance (DOI) *director* may require us to treat and process any *complaint* received by the State Department of Insurance by, or on behalf of, a *member* as a *grievance* as appropriate. We will process the State Department of Insurance *complaint* as a *grievance* when the *director* provides us with a written description of the *complaint.* We will have 15 business days from the date the *complaint* is sent to us to respond to the DOI's request for information.

The DOI Consumer Affairs Division will try to complete its review within a month. However, if the issue is a complex one, or if they need to gather more information, it may take longer. Once the review is completed, a copy of the response will be sent to the *member* along with a summary of their findings.

To file a DOI *complaint,* the *member* can do so electronically at https://doi.nebraska.gov/ or may call the toll-free Consumer Hotline at 1-877-564-7323 and request that a paper form be mailed to them.

External Review

An external review decision is binding on us. An external review decision is binding on the *member* except to the extent the *member* has other remedies available under applicable federal or state law. We will pay for the costs of the external review performed by the independent reviewer. The *member* or *authorized representative,* if applicable, may not file a subsequent request for external review involving the same *adverse determination* or *final adverse determination* for which the *member* has already received an external review decision.

The *member* has four (4) months from the date of a denial of payment on a claim or receipt of an *adverse determination*/*final adverse determination* notice to request an external review. An external review may be requested through the DOI via the external review secure portal, which will allow the member to check on the status of the external review at any time; it will also send an email notice of each event occurring as the external review progresses and email a determination immediately when the external review is complete. Alternatively, the member may print copies of the external review forms from the DOI website and mail or fax them to the address listed below.

The *member* should visit https://doi.nebraska.gov/ and click on "Appeal a Denied Health Insurance Claim" for full details for submitting an external review request.

The Nebraska Department of Insurance
PO Box 95087
Lincoln, NE 68509-5087
(877) 564-7323
https://doi.nebraska.gov/

External Review Secure Portal:
https://ecmp.nebraska.gov/DOI-ER/Account/Login?ReturnUrl=%2fDOI-ER%2f

Applicability/Eligibility

The external review procedures apply to:

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

After exhausting the internal review process, the *member* has four (4) months to make a written request to the Nebraska DOI after the date of receipt of our internal response.

1. The internal *appeal* process must be exhausted before the *member* may request an external review unless the *member* files a request for an expedited external review at the same time as an internal expedited *appeal* or we either provide a waiver of this requirement or fail to follow the *appeal* process;
2. A health plan must allow a *member* to make a request for an expedited external review with the plan at the time the member receives:
    a. An *adverse determination*, if the determination involves a medical condition of the *member* for which the timeframe for completion of an internal expedited *appeal* would seriously jeopardize the life or health of the *member* or would jeopardize the *member's* ability to regain maximum function, and the *member* or *authorized representative* has filed a request for an internal expedited *appeal;* and
    b. A *final adverse determination*, if the *member* has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the *member* or would jeopardize the *member's* ability to regain maximum function, or if the *final adverse determination* concerns an admission, availability of care, continued stay, or health care item or service for which the member received *emergency services*, but has not been discharged from a facility;
3. *Members* may request an expedited external review at the same time the internal expedited *appeal* is requested and an *Independent review organization* (*IRO*) will determine if the internal expedited *appeal* needs to be completed before proceeding with the expedited external review.

External review is available for an *adverse determination* or *final adverse determination* that involve 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.

External Review Process

Within one (1) business day after the date of receipt of a request for an external review, the *director* shall send a copy of the request to us.

We have five (5) business days (immediately for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether:

1. The *member* was a covered person at the time the item or service was requested or, in the case of a *retrospective review*, was the *member* a covered person at the time that the service was provided;
2. The service of the *adverse determination* or the *final adverse determination* is a *covered service* under the *member's* health plan, but for a determination that the service is not covered because it does not meet the health plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;
    a. The *member* has exhausted the internal process, unless the member is not required to exhaust the health plan's *appeal* process;
    b. The *member* has provided all of the information required to process an external review, including the release form;
    c. Within one (1) business day (immediately for expedited) after completion of the preliminary review, we will notify the *director* and *member* and, if applicable, the *authorized representative*, in writing as to whether the request is complete and eligible for external review. If the request:
        i. Is not complete, we will inform the *director* and *member* and, if applicable, the *authorized representative* in writing and include in the notice what information or materials are needed to make the request complete; or
        ii. Is not eligible for external review, we will inform the *director* and *member* and, if applicable, the *authorized representative* in writing and include in the notice the reasons for its ineligibility;
        iii. The *director* may specify the form and information to include in the notice of initial determination we send. The initial determination will include a statement informing the *member* and, if applicable, the *authorized representative* that the health plan's initial determination indicating the external review is ineligible or review may be *appealed* to the *director*;
        iv. Once the *director* receives a notice that a request is eligible for external review following the preliminary review conducted by us, the *director* will within one (1) business day after receipt of notice;
3. Assign an IRO on a random basis from a list of approved IROs compiled and maintained by the *director* to conduct the external review, and notify us of the name of the assigned IRO; and
4. Notify the *member* and, if applicable, the *authorized representative* in writing of the request's eligibility and acceptance for external review;
    a. In reaching a decision, the assigned IRO is not bound by any decision or conclusion reached during our *utilization review* process;
    b. The notice from the *director* to the member and, if applicable, the *authorized representative* will also advise that within five (5) business days of receipt of the notice the member may submit additional information that the IRO will consider when conducting the external review. The IRO is not required to consider any additional information submitted after five (5) business days;

5. Within five (5) business days after the date of assignment of the IRO, we must provide the documents and any information considered in making the *adverse determination* or *final adverse determination* to the IRO. **NOTE**: For expedited, after assignment of the IRO, we must provide the documents and any information considered in making the *adverse determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method;
6. If we fail to timely provide the documents and information, it will not delay the IRO from conducting the external review; however, the IRO may terminate the external review and make a decision to reverse the *adverse determination* or *final adverse determination*;
7. If documents and information are not received timely from us, within one (1) business day after making the decision, the IRO will notify the member and, if applicable, the *authorized representative*, the *director*, and us;
8. The assigned IRO will review all of the information and documents received by us and any other information submitted in writing to the IRO by the member or *authorized representative*;
9. Upon receipt of any information submitted by the member or *authorized representative*, the IRO must forward the information to us within one (1) business day;
10. Upon receipt of the information, we may reconsider our *adverse determination* or *final adverse determination*. If we reverse our determination, we must provide written notice of the decision to the member and, if applicable, the *authorized representative*, the IRO, and the *director* within one (1) business day after making such decision. The IRO will terminate the external review upon receipt of the notice from us;
11. In addition to the documents and information provided by us and the member, the assigned IRO to the extent the information or documents are available and the IRO considers them appropriate, will also consider the following in reaching a decision:
    a. The covered person's medical records;
    b. The attending health care professional's recommendation;
    c. Consulting reports from appropriate health care professionals and other documents.
    d. The terms of coverage under the covered person's health benefit plan to ensure that the IRO's decision is not contrary to the terms of coverage under the *member's* health benefit plan with us;
    e. The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, or associations.
    f. Any applicable clinical review criteria developed and used by us or *utilization review* designee; and
    g. The opinion of the IRO's clinical reviewer or reviewers after considering all identified information to the extent that the information or documents are available and the clinical reviewer or reviewers consider it appropriate.
12. Within 45 calendar days (not more than 72 hours for expedited) after the date of receipt of the request for an external review, the assigned IRO will provide a written notice of its decision to uphold or reverse the *adverse determination* or *final adverse determination* to the member and, if applicable, the *authorized representative*, the *director*, 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

13. Upon receipt of a notice of a decision by the IRO reversing the *adverse determination* or *final adverse determination, we will approve the covered service that was the subject of the* adverse *determination* or *final adverse determination*.

Expedited External Review

An expedited external review may be submitted orally or in writing. All necessary information will be transmitted between the member, the DOI *director*, assigned IRO, and us by telephone, External Review Secure Portal or other available similarly expeditious method. (See External Review Process.)

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

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

An expedited external review shall be resolved as expeditiously as the *member's* health condition requires, but in no event more than 72 hours after receipt of the request.

The member should visit https://doi.nebraska.gov/ and click on "Appeal a Denied Health Insurance Claim" for full details for submitting an expedited external review request.

Nebraska Department of Insurance
PO Box 95087
Lincoln, NE 68509-5087
(877) 564-7323
https://doi.nebraska.gov/

External Review Secure Portal:
https://ecmp.nebraska.gov/DOI-ER/Account/Login?ReturnUrl=%2fDOI-ER%2f

Grievance and appeal filing and key communication timelines:

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard Grievance	180 Calendar Days	3 Business Days	15 Business Days	15 Business Days
Standard Appeal(Adverse determination Grievance)	180 Calendar Days	3 Business Days	15 Business Days	15 Business Days
Expedited Appeal	180 Calendar Days	N/A	72 hours	N/A
External Review	4 Months	N/A	45 Calendar days	N/A
Expedited External Review	4 months	Immediately	72 Hours	N/A

GENERAL PROVISIONS

Entire Policy

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

Rescissions

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

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

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 *membe*r was covered under the *policy*.

After this *policy* has been in force for two years during the *members* lifetime, it becomes incontestable regarding statements in the application, except in cases of fraud. Only fraudulent misstatements may be used to void the *policy* or deny claims for losses or disabilities arising after the two-year period.

Conformity with State and Federal Laws

Any part of this *policy* which, on the *policy’s effective date*, is in conflict with the laws of the federal government or the laws of the state of Nebraska is changed to conform to the minimum requirements of Nebraska state law.

Personal Health Information (PHI)

Your health information is personal. We are committed to do everything we can 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 AmbetterHealth.com/en/NE/privacy-practices or call Member Services.

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

Language Assistance

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