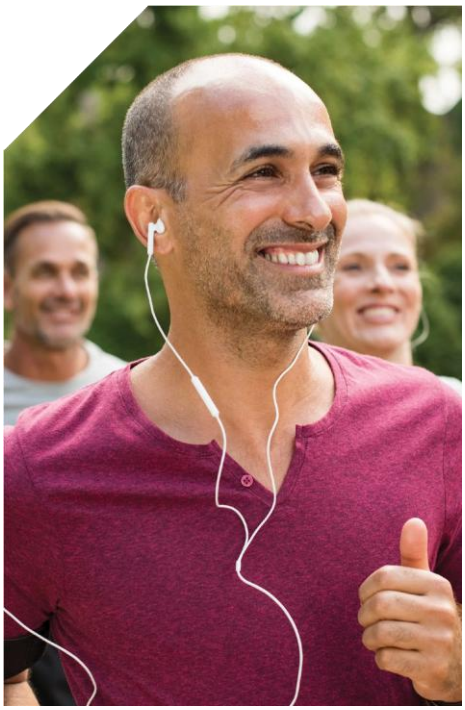


2026 EVIDENCE OF COVERAGE

Ambetter Health Solutions + Adult Vision + Adult Dental

AmbetterHealth.com

THIS *CONTRACT* REFLECTS THE KNOWN REQUIREMENTS FOR COMPLIANCE UNDER THE AFFORDABLE CARE ACT AS PASSED ON MARCH 23, 2010. AS ADDITIONAL GUIDANCE IS FORTHCOMING FROM THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND THE KANSAS DEPARTMENT OF INSURANCE, THOSE CHANGES WILL BE INCORPORATED INTO YOUR HEALTH INSURANCE POLICY.

AMBETTER HEALTH SOLUTIONS

Ambetter + Adult Vision + Adult Dental

Individual EPO Health Benefit Plan

Underwritten by Bankers Reserve Life Insurance Company of Wisconsin

Home Office:

8325 Lenexa Dr. Suite 410

Lenexa, KS 66214

Phone No. 1-833-543-3145 (TTY: 711)

AmbetterHealth.com

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

Individual Major Medical Expense Insurance Policy

In this *contract*, the terms you or your will refer to the *member* or *dependent members* enrolled in this *contract*, and we, our, or us will refer to Bankers Reserve Life Insurance Company of Wisconsin or Ambetter Health.

AGREEMENT AND CONSIDERATION

In consideration of your application and the timely payment of premiums, we will pay benefits to you, the *member*, for *covered services* as outlined in this *contract* and the corresponding *Schedule of Benefits*. Benefits are subject to *contract* definitions, provisions, limitations, and exclusions.

GUARANTEED RENEWABLE

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

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

Annually, we may change the rate table used for this *contract* form. Each premium will be based on the rate table in effect on that premium's due date. The *contract* plan, and age of *members*, type and level of benefits, and place of *residence* on the premium due date are some of the factors used in determining your premium rates. We have the right to change premiums, however, all premium rates charged will be guaranteed for a rating period of at least 12 months, unless enrollment related changes occur.

At least 31 calendar days' notice of any plan to take an action or make a change permitted by this clause will be delivered to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under this *contract* or a change in a *member's* health. While this *contract* is in force, we will not restrict coverage already in force.

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

RIGHT TO RETURN POLICY

Please read your *contract* carefully. If you are not satisfied, return this *contract* to us or to our agent within ten 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 *contract* will be considered null and void from the *effective date*.

IMPORTANT NOTICE

Please read the copy of the application attached to this *contract*. Carefully check the application and write to P.O. Box 25408 Little Rock, AR 72221 within ten calendar days, if any information shown on it is not correct and complete. This application is a part of the *contract*, and the *contract* was issued on the basis that answers to all questions and the information shown on the application are correct and complete.

IMPORTANT INFORMATION

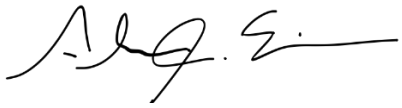
This *contract* reflects the known requirements for compliance under the Affordable Care Act as passed on March 23, 2010. As additional guidance is forthcoming from the US Department of Health and Human Services, and the Kansas Department of Insurance, those changes will be incorporated into your health insurance *contract*.

The coverage represented by this *contract* is under the jurisdiction of the Kansas Insurance Commissioner.

EPO is an abbreviation for Exclusive Provider Organization. What that means to you is services must be provided by a *network provider* to be covered except for *emergency services* and certain mental health office visits. You may pay 100 percent of the out-of-pocket cost up to your out-of-pocket maximum for these limited *covered services* provided by *non-network providers*.

This *contract* does not include pediatric dental services. Please contact your insurance carrier or producer or seek assistance through Healthcare.gov, if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

Bankers Reserve Life Insurance Company of Wisconsin



Alan Silver, President

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INTRODUCTION

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

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

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

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

How to Contact Us

Ambetter Health
8325 Lenexa Dr.
Suite 410
Lenexa, KS 66214

Normal Business Hours of Operation 8:00 a.m. to 8:00 p.m. local time, Monday through Friday

Member Services 1-833-543-3145
TTY Line 711
Emergency 911
Suicide and Crisis Lifeline: 988 (call or text)
24/7 Nurse Advice Line ..... 1-833-543-3145 (TTY: 711)

Interpreter Services

Ambetter Health has a free service to help *members* who speak languages other than English. These services ensure that you and your *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 have medical interpreters to assist with languages other than English via phone. An interpreter will not go to a *provider's* office with you. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

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

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

You have the right to:

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

9. See your medical records.
10. Be kept informed of covered and non-covered services, program changes, how to access services, *PCP* assignment, *providers*, advance directive information, *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.
11. A current list of *network providers*.
12. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
13. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, ethnicity, race, religion, gender, sex, sexual orientation, national origin, physical or mental disability, or expected health or genetic status.
14. Access *medically necessary* urgent and *emergency services* 24 hours a day, seven days a week.
15. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.
16. Refuse treatment to the extent the law allows without jeopardizing future treatment and be informed by your *provider(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 option that may help you. You will make the final decision.
17. Select your *PCP* within the *network*. You also have the right to change your *PCP* or request information on *network providers* close to your home or work.
18. Know the name and job title of people giving you care. You also have the right to know which *physician* is your *PCP*.
19. An interpreter when you do not speak or understand the language of the area.
20. A second opinion by a *network provider*, if you want more information about your treatment or would like to explore additional treatment options.
21. Make advance directives for health care decisions. This includes planning treatment before you need it.
22. Determine what actions should be taken regarding your health if you are no longer able to make decisions for your health because of *illness* or because you are incapacitated. You have the right to have your wishes known by completing advance directive forms. Advance directive forms are forms you can complete to protect your rights for medical care. They 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.

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

IMPORTANT INFORMATION

Provider Directory

A listing of *network providers* is available online at AmbetterHealth.com. We have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide you health care 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, gender, languages spoken, and whether or not they are currently accepting new patients. Your search will produce a list of *providers* based on your search criteria and will give you other information such as name, address, phone number, office hours, specialty, and board certifications.

At any time, you can request a printed copy of the Provider Directory at no charge by calling Member Services. We can help you pick a *PCP*. We can make your choice of *PCP* effective on the next business day.

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

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

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

Member Identification Card

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

The *member* identification card will show your name, *member* identification number, and *copayment amounts* required at the time of service. If you do not get your *member* identification card within a few weeks after you enroll, please call Member Services. We will send you another card. A temporary *member* identification card can be downloaded from AmbetterHealth.com.

Website

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

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

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

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 *contract*. You will only be responsible for paying your *member cost share* for these services, which is calculated as if you had received the services from a *network provider* and based on the recognized amount as defined in *applicable law*.

Quality Improvement

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

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

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

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

As innovative technologies and solutions are established 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 Health 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*.

DEFINITIONS

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

Wherever used in this *contract*:

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

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

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

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

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

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

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

balance billing protections and otherwise covered under your *contract*. 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 Health 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 Health 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 center 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 means a request to reconsider a decision about the *member's* benefits where either a service or claim has been denied.

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

Applied behavior analysis or ***ABA*** means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Autism spectrum disorder means a group of complex disorders represented by repetitive and characteristic patterns of behavior and difficulties with social communication and interaction. The symptoms are present from early childhood and affect daily functioning as defined by the most recent edition of the Diagnostic and Statistical manual of Mental Disorders or the International Classification of Diseases.

Authorization or ***authorized*** means our decision to approve the *medical necessity* or the appropriateness of care for a *member* by the *member's primary care physician (PCP)* or *provider*. *Authorizations* are not a guarantee of payment.

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

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

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

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

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

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

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

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

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

Calendar year means the period beginning on the initial *effective date* of this *contract* 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, known as a care manager, assists a *member* through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and health care benefits available to a *member*. *Care management* is instituted when mutually agreed to by us, the *member* and the *member's physician*.

Center of Excellence means a *hospital* that:

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

Claimant means the *member* or *member's authorized representative* who has contacted the plan to file a *grievance* or *appeal* or who has contacted the Kansas Department of Insurance to file an external review.

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

Complications of pregnancy means:

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

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

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

Contract when italicized, means this *contract* as issued and delivered to you. It includes the attached pages, the applications, and any amendments.

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

Cosmetic treatment means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an *injury*, *illness*, or congenital anomaly. *Cosmetic treatment* does not include *reconstructive surgery* when the service is incidental to or follows *surgery* resulting from trauma, infection or other diseases of the involved part, and *reconstructive surgery* because of congenital disease or anomaly of a *dependent member* that has resulted in a functional defect.

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

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

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

Custodial care means 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 amount or ***deductible*** means the amount that you must pay in a calendar year for covered expenses before we will pay benefits. For family coverage, there is a family *deductible*

amount which is two times the individual *deductible amount*. Both the individual and the family *deductible amounts* are shown in your *Schedule of Benefits*.

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

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

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

Dental expenses 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 expenses* regardless of the reason for the services.

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

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

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

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

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

It is your responsibility to notify Member Services if your child ceases to be an *eligible child*. You must reimburse us for any benefits that we pay for a child at a time when the child did not qualify as an *eligible child*.

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

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

b. For all other *covered services* received from a *non-network provider* for which any needed *authorization* is received from us, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the *provider* as payment in full (you will not be billed for the difference between the negotiated fee and the *provider's* charge). If there is no negotiated fee agreed to by the *provider* with us, the *eligible expense* is the greatest of the following: (i) the amount that would be paid under Medicare; (ii) the amount for the *covered service* calculated using the same method we generally use to determine payments for *non-network providers*; or (iii) the contracted amount paid to *network providers* for the *covered service* (if there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts) In addition to applicable *cost sharing*, you may be *balance billed* for these services.

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

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

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

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

Expedited appeal means a situation in which a *physician* with knowledge of the *member's* medical condition determines that the standard timeframe for an *appeal* decision could seriously jeopardize the life or health of the *member* or the *member's* ability to regain maximum function, or would subject the *member* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *appeal*. Ongoing *emergency* or continued hospitalization *appeals* will follow the expedited *appeals* process.

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

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (FDA) regulation, regardless of whether the trial is subject to FDA oversight;
2. An *unproven service*;
3. Subject to FDA approval, and:
    a. It does not have FDA approval;
    b. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation;
    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*;
    d. It has FDA approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the FDA or has not been determined through peer reviewed medical literature to treat the medical condition of the *member*.
4. *Experimental or investigational* according to the *provider's* research protocols.

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

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.

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 that are 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 expense under the *contract*. The decision to apply *physician* specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by us.

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

1. Provision of services;
2. Determination to reform or rescind a *contract*; and
3. Claims practices.

Habilitation or ***habilitation services*** means health care services that help you keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* or outpatient settings.

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*.

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

Hospital means an institution that:

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

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

Illness means a sickness, disease, or disorder of a *member*.

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

Injury means accidental bodily damage sustained by a *member* that is the direct cause of the condition for which benefits are provided, independent of disease or body infirmity or any other cause that occurs while this *contract* is in force. All injuries due to the same accident are deemed to be one *injury*.

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

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

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

Loss means an event for which benefits are payable to a *member* under this *contract*. Expenses incurred prior to this *contract's effective date* are not covered, however, expenses incurred beginning on the *effective date* of insurance under this *contract* are covered.

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

Manipulative therapy means treatment applied to the spine or joint structures to correct vertebral or joint malposition and to eliminate or alleviate somatic dysfunction including, but not limited to, manipulation, myofascial release or soft tissue mobilization. Treatment must demonstrate pain relief and continued improvement in range of motion and function and cannot be performed for maintenance care only. *Manipulative therapy* is not limited to treatment by manual means.

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 *contract*: rolfer, hypnotist, 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 or ***medical necessity*** means our decision as to whether any medical service, supply or treatment *authorized* by a *physician* to prevent, *stabilize*, diagnose or 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,* except as specifically provided under the *contract*;
6. 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;
7. Is no more costly than an alternative *covered service* that is likely to produce equivalent therapeutic outcome; 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 plans, most individual plans sold outside of the Health Insurance 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 health care facilities, medical clinics, *behavioral health* clinics, acupuncturists, chiropractors, massage therapists, nurse practitioners, addiction medicine practitioners, etc.) who have *contracts* with us, or our contractor or subcontractor, and have agreed to provide health care services to our *members* for an agreed upon fee. *Members* will receive most if not all of their health care services by accessing the *network*.

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

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

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

Non-elective cesarean section means:

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

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

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

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

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

5. The *non-network provider* provides the *member* the notice document and the consent document together, but physically separate from other documents.
6. The *non-network provider* provides the *member* a copy of the signed written *notice and consent* through email or mail.

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

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

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

Other plan means a form of coverage with which coordination is allowed. Separate parts of a plan for *members* of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan, and there is no Coordination of Benefits (COB) among the separate parts of the plan. "Plan" includes any *subscriber contracts*, uninsured arrangements of group or group-type coverage, group coverage through closed panel plans, group-type *contracts*, the medical care components of long-term care *contracts*, such as skilled nursing care, Medicare or other governmental benefits limited to the *hospital*, medical and surgical benefits of the governmental program, group and nongroup insurance *contracts* for the cost of dental care, nongroup insurance *contracts* issued on or after January 1, 2014, and nongroup coverage through closed panel plans issued on or after January 1, 2014. *Other plan* will not include Medicaid.

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

Outpatient services means services that include facility, ancillary, and professional charges when given as an outpatient at a *hospital*, alternative care facility, retail health clinic, or other *provider* as determined by us. 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 *member* by blood, marriage or adoption or who is normally a member of the *member's* household.

Post-service claim means any claim for benefits for medical care or treatment to which the terms of this *contract* do not condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining the medical care.

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

Pre-service claim means any claim for benefits for medical care or treatment that requires the approval of us in advance of the *claimant* obtaining the medical care.

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

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

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

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

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

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

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

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

Provider means a *physician* or other person which is licensed, accredited or certified to perform specified health care services.

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

Qualified individual means, an individual who has been determined eligible to enroll in a *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*, as well as *rehabilitation therapy*, cardiac *rehabilitation therapy*, and pain management programs. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been medically *stabilized* and begins to receive *rehabilitation therapy* or treatment under a pain management program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Spinal manipulation 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*.

Spouse means the person to whom you are lawfully married.

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

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

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

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

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.

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

Surrogate means an individual who, as part of a *surrogacy arrangement*, (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.

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.

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 *contract* was completed by the *member*, including all *tobacco* and nicotine products, e-cigarettes or vaping devices, but excluding religious and ceremonial uses of *tobacco*.

Unproven service(s) means services, including medications that are determined not to be effective for treatment of the medical condition, and/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; and
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.

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*. *Virtual 24/7 Care* services can be accessed through the *Ambetter-designated telehealth provider*'s website.

DEPENDENT MEMBER COVERAGE

Dependent Member Eligibility

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

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

Effective Date for Initial Dependent Members

The *effective date* for *dependent members*, if any, will be the same as your initial coverage date. Only *dependent members* included in the initial enrollment application for this *contract* will be covered on your *effective date*.

Coverage for a Newborn Child

An *eligible child* born to you, or a covered family *member* will be covered from the time of birth until the 31st calendar day after birth, unless we have received notice from you. A covered newborn child will not be subject to the *deductible amount* or any *cost sharing* amounts for the first 31 calendar days of coverage.

Additional premium will be required to continue coverage beyond the 31st calendar day after the date of birth. If notice of the newborn is given to us 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 given to us 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 that you have enrolled the child in accordance with these *contract* terms.

Coverage for an Adopted Child

An *eligible child* legally placed for adoption with a *member* 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. For a newly born child, coverage will be in place from the date of birth if a petition of adoption is filed within 31 calendar days of the date of birth. For a child adopted within 90 calendar days of birth, delivery and obstetrical expenses of the birth mother will be covered.

The child will be covered on the same basis as any other *dependent member*.

Additional premium will be required to continue coverage beyond the 31st calendar day following placement of the child. The required premium will be calculated from the date of placement for adoption. Coverage of the child will terminate on the 31st calendar day following placement, unless we have received both: a) Notification of the addition of the child 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 date that you or your *spouse* assume physical custody of the child for the purpose of adoption pursuant to an adoption proceeding.

Adding Other Dependent Members

If you apply in writing, or directly at enroll.ambetterhealth.com, for coverage on a *dependent member* and you pay the required premiums, we will send you written confirmation of the added *dependent member's effective date* of coverage and identification cards for the added *dependent member*.

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 *hospital* or benefits under the prior coverage are exhausted, whichever is earlier.

If there is no prior coverage or no continuation of *inpatient* coverage after the *effective date*, your Ambetter Health coverage will apply for *covered services* related to the *inpatient* coverage after your *effective date*. Ambetter Health coverage requires you notify Ambetter Health 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 *allowed amount*, and you may be billed for any balance of costs above the *allowed amount*.

ELIGIBILITY AND ENROLLMENT

For All Members

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

1. The primary *subscriber* residing outside the *service area* or moving permanently outside the *service area* of this plan;
2. The date of a *member's* death;
3. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *contract* or the date that we have not received timely premium payments in accordance with the terms of this *contract*;
4. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or
5. The last day of the month we receive a request from you to terminate this *contract*, or any later date stated in your request will be effective the last day of the requested month but no further than 60 calendar days in advance.

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*. For *eligible children*, coverage will terminate the 31st day of December the year that the *dependent member* turns 26 years of age.

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

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

Open Enrollment

Each year there will be an open enrollment period of coverage. The open enrollment period begins November 1, 2025, and extends through January 15, 2026. If you enroll on or before December 15, 2025, your coverage will be effective on January 1, 2026.

If you have material modifications (examples include a change in life event (marriage, death) or family status) or questions related to your health insurance coverage, contact Member Services, or you can access your Ambetter Health Online Member Account to process these changes. You can access your consumer dashboard at enroll.ambetterhealth.com to process these changes.

Special and Limited Enrollment

A *qualified individual* has 60 calendar days to report a qualifying event to us, and could be granted a 60-calendar day Special Enrollment Period as a result of one of the following events:

1. A *qualified individual* or *dependent member* experiences a *loss of minimum essential coverage*, non-calendar year group or individual health insurance coverage, *pregnancy*-related coverage, access to health care services through coverage provided to a pregnant *member's* unborn child, or medically needed coverage;

2. A *qualified individual* gains a *dependent member* or becomes a dependent through marriage, birth, adoption or placement for adoption, placement in foster care, or a child support order or other court order;
    a. In the case of marriage, at least one *spouse* must demonstrate having *minimum essential coverage* as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 calendar days preceding the date of marriage.
3. A *qualified individual's* enrollment or non-enrollment in a health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, or employee, or its instrumentalities as evaluated and are determined by the applicable state authority or us;
4. A *qualified individual* or *member* gains access to a new health plan as a result of a permanent move;
5. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
6. A *qualified individual* or *dependent member* 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;
7. A *qualified individual* or *dependent member* is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 calendar days after the qualifying event;
8. A *qualified individual* newly gains access to an employer sponsored individual coverage health reimbursement arrangement, HRA (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA); or
9. A *qualified individual* or *dependent* is enrolled in COBRA continuation coverage and employer contributions to or government subsidies completely cease.

If you have or believe you have experienced a qualifying event (common examples include a change in life event such as marriage, death or other change in family status), contact Member Services.

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 Health 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

Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 60 calendar day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *contract* will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. We will notify the *member,* 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 *member* to pay his or her premiums and this is communicated on your monthly billing statements. Ambetter Health 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 Health premiums on your behalf:

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

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

Health Savings Account (HSA)

A Health Savings Account (HSA) is a special tax-exempt custodial account or trust owned by a *member* where contributions to the account may be used to pay for current and future qualified

medical expenses. Please refer to your *Schedule of Benefits* to see if the plan you are enrolled in has an HSA. For *members* enrolled in an HSA-compatible plan, the following terms apply.

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

This Evidence of Coverage is administered by Ambetter Health and underwritten by Bankers Reserve Life Insurance Company of Wisconsin. Neither entity is an HSA trustee, HSA custodian or a designated administrator for HSAs. Bankers Reserve Life Insurance Company of Wisconsin, its designee and its affiliates, including Ambetter Health, do not provide tax, investment or legal advice to *members*. Refer to IRS guidance for eligible medical expenditures under an HSA.

MEMBERS ARE SOLELY RESPONSIBLE FOR ADHERING TO ALL FEDERAL REGULATIONS AND GUIDELINES CONCERNING HSA MAXIMUM *ALLOWED AMOUNT*, CONTRIBUTIONS AND QUALIFIED WITHDRAWALS. IN ADDITION, EACH *MEMBER* WITH AN HSA IS RESPONSIBLE FOR NOTIFYING HIS/HER HSA CUSTODIAN OR TRUSTEE IF ENROLLMENT UNDER THEIR HSA PLAN HAS BEEN CANCELED OR TERMINATED.

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

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

Reinstatement

If your *contract* lapses due to nonpayment of premium, it may be reinstated provided:

1. We receive from you a written application for reinstatement within one year after the date coverage lapsed; and
2. The written application for reinstatement is accompanied by the required premium payment.

If we require a written application and issue a conditional receipt for the premium, your *contract* will be reinstated upon our approval of the application. If we do not approve or deny the application within 45 calendar days of the conditional receipt, the *contract* will be reinstated automatically on the 45th day, unless we notify you in writing of our disapproval before that time.

Premium accepted for reinstatement may be applied to a period for which premium had not been paid. The period for which back premium may be required will not begin more than 60 calendar days before the date of reinstatement. The reinstated policy shall cover only *losses* from accidental *injury* sustained after the date of reinstatement, and *losses* due to sickness that begin more than ten calendar days after that date.

The *rescissions* provision will apply to statements made on the reinstatement application, based on the date of reinstatement. In all other respects, you and we will have the same rights as before your *contract* lapsed.

Misstatement of Age

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

Change or Misstatement of Residence

If you change your *residence*, you must notify us of your new *residence* within 60 calendar days of the change. As a result, your premium may change, and you may be eligible for a special enrollment period. See the special enrollment periods provision for more information. Your premium will be based on your new *residence* beginning on the first premium due date/first day of the next calendar month after the change. If your *residence* is misstated on your application, or you fail to notify us of a change of *residence*, we will apply the correct premium amount beginning on the first premium due date/first day of the first full calendar month you resided at that place of *residence*. If the change results in a lower premium, we will refund any excess premium. If the change results in a higher premium, you will owe us the additional premium.

Misstatement of Tobacco Use

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

COST SHARING FEATURES

Cost Sharing Features

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

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

Deductible

The *deductible amount* means the amount of *covered service* that must be paid by each/all *members* before any benefits are payable. If on a family plan, if one *member* of the family meets his or her *deductible*, benefits for that *member* will be paid. 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.

Copayment Amounts

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

Coinsurance Amount

A *coinsurance amount* is your share of the cost of a service. *Members* may be required to pay *coinsurance amount* in addition to any applicable *deductible amount*(s) due for a *covered service* or supply. *Coinsurance amounts* do not apply toward the *deductible* but do apply toward your *maximum out-of-pocket amount*.

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

Maximum Out-of-Pocket

You must pay any applicable *copayments*, *coinsurance amounts*, or *deductible amounts* required until you reach the *maximum out-of-pocket amount* shown in your *Schedule of Benefits*. After the

maximum out-of-pocket amount is met for an individual, we will pay 100 percent of the cost for *covered services*. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket amount*. For the family *maximum out-of-pocket amount*, once a *member* has met the individual *maximum out-of-pocket amount*, the remainder of the family *maximum out-of-pocket amount* can be met with the combination of any one or more *members*' *eligible expenses*.

After the *maximum out-of-pocket amount* is met for an individual, Ambetter Health pays 100 percent of *eligible expenses* for that individual. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket amount*. Both the individual and the family *maximum out-of-pocket amounts* are shown in your *Schedule of Benefits*.

For family coverage, the family *maximum out-of-pocket amount* can be met with the combination of any one or more *members*' *eligible expenses*. A *member's maximum out-of-pocket* will not exceed the individual *maximum out-of-pocket amount*.

If you are a covered *member* in a family of two or more *members*, you will satisfy your *maximum out-of-pocket* when:

1. You satisfy your individual *maximum out-of-pocket*; or
2. Your family satisfies the family *maximum out-of-pocket* amount for the calendar year.

If you satisfy your individual *maximum out-of-pocket*, you will not pay any more *cost sharing* for the remainder of the calendar year, but any other eligible *members* in your family must continue to pay *cost sharing* until the family *maximum out-of-pocket* is met for the calendar year.

Refer to your *Schedule of Benefits* for *coinsurance amounts* and other limitations.

The amount payable will be subject to:

1. Any specific benefit limits stated in the *contract*;
2. A determination of *eligible expenses*; and
3. Any reduction for expenses incurred at a *non-network provider*. Please refer to the information on your *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 we agreed to pay and the full *billed amount* for a service. This is known as *balance billing*. This amount is likely more than *network* costs for the same service and might not count toward your annual *maximum out-of-pocket* limit. However, you are not responsible for *balance billing* when *balance billing protections* apply to *covered services*.

ACCESS TO CARE

Primary Care Physician (PCP)

In order to obtain benefits, you must designate a *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. 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 *PCPs* at our website and accessing the “Find a Doctor” page or by contacting Member Services.

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

Changing Your PCP

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

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 1-833-543-3145 (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.

Network Availability

Your *network* is subject to change. The most current *network* may be found online at our website or by contacting us at the number shown on your *member* identification card. A *network* may not be available in all areas. If you move to an area where we are not offering access to a *network*, please contact Member Services prior to moving or as soon as possible. You may have the opportunity to disenroll from coverage under this *contract* and enroll in a different health plan with a *network* in that area. **Note:** Services from *non-network providers* are generally not *covered services* under this *contract*, except when *balance billing protections* apply to a *covered service* provided by a *non-network provider*. If you receive *covered services* from *non-network providers* that are not subject to *balance billing protections* benefits will be calculated in accordance with the terms of this *contract* for *non-network providers*.

In the event your *network provider* is terminated from the *network* for any reason, continuation of care for a period up to 90 calendar days may be provided, if the continuation of such care is *medically necessary* and where the *member* has special circumstances such as a disability, a life-threatening *illness* or is in the third trimester of *pregnancy*.

Coverage under Other Contract Provisions

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

Non-Emergency Services

If you are traveling outside of the Ambetter Health *service area*, you may be able to access *providers* in another state if there is an Ambetter Health plan located in that state. You can locate Ambetter Health *providers* outside of Kansas by searching the relevant state in our *provider* directory at guide.ambetterhealth.com. Not all states have Ambetter Health plans. If you receive care from an Ambetter Health *provider* outside of the *service area*, you may be required to receive *prior authorization* for non-emergency services. Contact Member Services at the phone number on your *member* identification card for further information.

Emergency Services Outside of Service Area

We cover *emergency* care 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 to the nearest emergency room. Be sure to a call us and report your *emergency* within one business day. You do not need *prior authorization* for *emergency services*.

Hospital Based Providers

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

Continuity of Care

Under the federal No Surprises Act, effective January 1, 2022, if a *member* is a *continuing care patient* with respect to a *network provider* and the contractual relationship with the *provider* is terminated, such that the *provider* is no longer in the network; or benefits are terminated because of a change in the terms of the participation of the *provider*, as it pertains to the benefit the *member* is receiving, then we will:

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

New Technology

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

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

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

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

Preferred Partnership

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

MAJOR MEDICAL EXPENSE BENEFITS

Ambetter Health provides coverage for health care services for a *member* and/or *dependent members*. Some services require *prior authorization*.

Copayment, deductible and *coinsurance amounts* must be paid to your *network provider* at the time you receive services.

All *covered services* are subject to conditions, exclusions, limitations, terms and provision of this *contract*. *Covered services* must be *medically necessary* and not *experimental or investigational*.

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

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

Acupuncture Services

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

Acquired Brain Injury Services

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

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

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration. *Custodial care* and long-term nursing care are not *covered services* under this *policy*.

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

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

Ambulance Service Benefits

Air Ambulance Service Benefits

Covered services will include ambulance services for transportation by fixed wing and rotary wing air ambulance, from home, scene of accident, or 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 us;
4. When ordered by an employer, school, fire or public safety official and the *member* is not in a position to refuse; or
5. When a *member* is required by us to move from a *non-network provider* to a *network provider*.

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

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

Limitations:

Benefits for air ambulance services are limited to:

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

Exclusions:

No benefits will be paid for:

1. Air ambulance services covered by a local governmental or municipal body, unless otherwise required by law.

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

Prior authorization is not required for *emergency* ambulance transportation. **Note:** Non-emergency ambulance transportation requires *prior authorization*.

Note: You should not be *balance billed* for services from a non-network ambulance *provider*, beyond your *cost share*, for air ambulance services.

Ambulance Services (Ground and Water)

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

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

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

Exclusions:

No benefits will be paid for:

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

ASD and Developmental/Physical Disabilities Expense Benefit

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. Speech therapy;
5. *Habilitation services* for individuals with a diagnosis of *autism spectrum disorder*;
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 amount* will apply to each *provider*.

Care Management Programs

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

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

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

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

Clinical Trials for Cancer and Other Life-Threatening Illnesses

Covered service expenses for the routine patient care costs incurred by a *member* enrolled in an approved clinical trial related to cancer, including leukemia, lymphoma, and bone marrow stem cell disorders, or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, if the *member's physician* determines that:

1. The *member* or prospective *member* has been diagnosed with cancer or other life-threatening *illness* and accepted into a phase I, phase II, phase III or phase IV clinical trial for cancer or the specific life-threatening *illness*;

2. The treating *physician* who is providing covered health care services to the *member* recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the *member*;
3. There is no clearly superior non-investigational treatment alternative; and
4. Available clinical or preclinical data provide a reasonable expectation that the treatment provided in the clinical trial will be at least as effective as any non-investigational alternative.

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

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

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

Covered service expenses include the costs of:

1. Prevention, diagnosis, treatment, and palliative care of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted;
2. Medical care for an approved clinical trial related to cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, that would otherwise be covered under a health care insurance plan if the medical care were not in connection with an approved clinical trial;
3. Items or services necessary to provide an investigational item or service;
4. The diagnosis or treatment of complications;
5. A drug or device approved by the FDA without regard to whether the FDA approved the drug or device for use in treating a patient's particular condition, but only to the extent that the drug or device is not paid for by the manufacturer, distributor, or *provider* of the drug or device;
6. Services necessary to administer a drug or device under evaluation in the clinical trial; and
7. Transportation for the patient that is primarily for and essential to the medical care.

Covered service expenses do not include:

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

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

Dental Benefits – Adults 19 years of age or older

Coverage for *dental services* is provided for adults, age 19 and older, for Preventive and Diagnostic, Basic Services, and Major Services from a *network provider*.

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

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

Services not covered:

1. Out of *network* services;
2. Dental services that are not necessary or specifically covered;
3. Hospitalization or other facility charges;
4. *Prescription drugs* dispensed in the dental office;
5. Any dental procedure performed solely as a cosmetic procedure;
6. Charges for dental procedures completed prior to the *member's effective date* of coverage;
7. Services provided by an anesthesiologist;
8. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by abrasion, abfraction, or erosion, realignment of teeth, periodontal splinting, and gnathologic recordings;
9. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles;
10. Any artificial material implanted or grafted into soft tissue, surgical removal of implants, and implant-related services;

11. Sinus augmentation;
12. Surgical appliance removal;
13. Intraoral placement of a fixation device;
14. Oral hygiene instruction, tobacco or nicotine counseling, nutritional counseling or high-risk *substance use disorder* counseling;
15. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture;
16. Any oral *surgery* that includes surgical endodontics (apicoectomy and retrograde filling);
17. Analgesia (nitrous oxide);
18. Removable unilateral dentures;
19. Temporary procedures;
20. Splinting;
21. Temporomandibular Joint (TMJ) disorder appliances, therapy, films and arthrograms;
22. Oral pathology laboratory;
23. Consultations by the treating *provider* and office visits;
24. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
25. Veneers (bonding of coverings to the teeth);
26. Orthodontic treatment procedures;
27. Orthognathic *surgery*;
28. Athletic mouth guards; and
29. Space maintainers.

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*. 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 an artificial kidney machine.

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

Disposable Medical Supplies

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

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

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

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

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

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

Benefits for repairs and replacement do not include the following:

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

We may establish reasonable quantity limits for certain supplies, equipment or appliance described below. See your *Schedule of Benefits* for benefit levels or additional limits.

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 costs 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 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. Tracheotomy tube.
6. Cardiac, neonatal and sleep apnea monitors.
7. Augmentative communication devices are covered when we approve based on the *member's* condition.
8. Rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.

9. Rental of one Continuous Passive Motion (CPM) machine per *member* following a covered joint *surgery.* Rental costs must not be more than the purchase price of a new item.
10. One pair of foot orthotics per *member*.

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

Exclusions:

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

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

Medical and surgical supplies

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

Covered services may include, but are not limited to:

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

Exclusions:

Non-covered services include but are not limited to:

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

Prosthetics

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

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

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

Covered services may include, but are not limited to:

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

Exclusions:

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

1. Dentures, replacing teeth or structures directly supporting teeth.

2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Wigs when purchased through other than a *network* DME *provider*.
5. Penile prosthesis when *medical necessity* criteria are not met or is strictly a cosmetic procedure.

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* may include, but are not limited to, the following:

1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.
10. *Medically necessary* corrective footwear; *prior authorization* may be required.

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

Exclusions:

Non-covered services and/or devices include, but are not limited to:

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

Emergency Services

If you experience an *emergency condition*, you should call 911 or 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 treat you within the emergency room may not be contracted with us. If that is the case, they may not *balance bill* you for the difference between our *allowed amount* and their *billed amount*.

Family Planning and Contraception

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

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

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

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

1. *Covered services* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision;
2. Covered 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; and
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the FDA;
3. Covered expenses for *non-provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners*;
4. Outpatient *rehabilitation/habilitation* therapy may include; occupational, physical, and speech therapy;
5. Coverage includes cardiac and pulmonary *rehabilitation*.

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

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

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

Home Health Care Expense Benefits

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

1. *Home health aide services*, only if provided in conjunction with skilled registered nurse or licensed practical nursing services;

2. 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. *Necessary medical supplies*;
6. Rental of the *durable medical equipment*;
7. Hemodialysis, and for the processing and administration of blood or blood components; and
8. Intravenous medication and pain medication are *covered services* 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 *authoriz*e before the purchase.

Educational visits are limited to three visits per year.

Limitations:

Home health care services and benefits are subject to *prior authorization* requirements as outlined in this *contract.* See your *Schedule of Benefits* for benefit levels or additional limits for expenses related to *home health aide services*. *Home health care* services not in conjunction with a registered or licensed practical nurse and home health aide are not covered.

Exclusions:

No benefits will be payable for charges related to *respite care*, or *custodial care* under the Home Health Care Service Expense Benefit sections.

Hospice Care Expense Benefits

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

Covered services include:

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

7. *Terminal illness counseling* of *members* of the *member's immediate family*; and
8. *Bereavement counseling*.

Benefits for *hospice inpatient*, home and outpatient care is subject to *prior authorization* as outlined in this *contract*. For each day the *member* is confined in a *hospice*, benefits for room and board will not exceed the most common semiprivate room rate of the *hospital* or nursing home with which the *hospice* is associated.

Exclusions and Limitations:

Any exclusion or limitation contained in the *contract* regarding:

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

Hospital Benefits

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

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

Infertility Services

Covered services for infertility treatment are limited to diagnostic testing to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy and semen analysis. Benefits are included to treat the underlying medical conditions that cause infertility (such as endometriosis, obstructed fallopian tubes and hormone deficiency).

Long Term Acute Care

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

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

1. Complex wound care:
    a. Daily *physician* monitoring of wound.

b. Wound requiring frequent complicated dressing changes, and possible repeated debridement of necrotic tissue.

c. Large wound with possible delayed closure, draining, and/or tunneling or high output fistulas.

d. Lower extremity wound with severe ischemia.

e. Skin flaps and grafts requiring frequent monitoring.

2. Infectious disease:

a. Parenteral anti-infective agent(s) with adjustments in dose.

b. Intensive sepsis management.

c. Common conditions include osteomyelitis, cellulitis, bacteremia, endocarditis, peritonitis, meningitis/encephalitis, abscess and wound infections.

3. Medical complexity:

a. Primary condition and at least two other actively treated co-morbid conditions that require monitoring and treatment.

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

4. Rehabilitation:

a. Care needs cannot be met in a *rehabilitation* or skilled nursing facility.

b. Patient has a comorbidity requiring acute care.

c. Patient is able to participate in a goal-oriented *rehabilitation* plan of care.

d. Common conditions include CNS conditions with functional limitations, debilitation, amputation, cardiac disease, orthopedic *surgery*.

5. Mechanical ventilator support:

a. Failed weaning attempts at an acute care facility.

b. Patient has received mechanical ventilation for 21 consecutive days for 6 hours or more/per day.

c. Ventilator management required at least every 4 hours as well as appropriate diagnostic services and assessments.

d. Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions.

e. Patient is hemodynamically stable and not dependent on vasopressors.

f. Respiratory status is stable with maximum PEEP requirement 10 cm H2O, and FiO2 60% or less with O2 saturation at least 90%.

g. Common conditions include complications of acute lung *injury*, disorders of the central nervous and neuromuscular systems, and cardiovascular, respiratory, and pleural/chest wall disorders.

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

Lymphedema Benefit

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

Mammography Coverage

Covered services for a *member* will include mammography 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), 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 found in the Preventive Care Expense Benefits section.

Maternity Care

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

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

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

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

Note: This provision does not amend the *contract* to restrict any terms, limits, or conditions that may otherwise apply to *surrogates* and children born from *surrogates*. Please reference the General Limitations 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. Covered newborns do not incur *cost share* for the first 31 calendar days of coverage. Each type of *covered service* received by the newborn child, from birth through the 31st day, will not be subject to his/her own *cost sharing* (*deductible, copayment* or *coinsurance amount*). After 31 calendar days, *cost sharing* will apply if the newborn child is enrolled. Please refer to the Dependent Member Coverage section of this document for details regarding coverage for a newborn child/coverage for an adopted child.

Covered services for newly born children covered under the *contract* includes coverage of *injury* or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; routine and necessary immunizations. For purposes of this *contract*, “routine and necessary immunizations” consists of at least five doses of vaccine against: diphtheria, pertussis, tetanus; at least four doses of vaccine against polio and Haemophilus B (Hib); and three doses of vaccine against Hepatitis B; two doses of vaccine against measles, mumps and rubella; one dose of vaccine against varicella and such other vaccines and dosages as may be prescribed by the secretary of health and environment. Such routine and necessary immunizations administered to each newly born child from birth to 72 months of age and shall not be subject to any *deductible, copayment or coinsurance amount* requirements.

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 Limitations 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 Department
8325 Lenexa Dr., Suite 410
Lenexa, KS 66214

In the event that a *member* fails to comply with this provision, we reserve our right to enforce this *contract* 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 *contract*, plus interest, attorneys’ fees, costs and all other remedies available to us.

Newborns’ and Mothers’ Health Protection Act Statement of Rights

If expenses 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.

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

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

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

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 center*. 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. This coverage does not apply to treatment for temporomandibular joint disorders (TMJ).

Medical Foods

We cover medical foods and formulas for:

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

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

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.

Medical and Surgical Expense Benefits

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

1. For *surgery* in a *physician*'s office, an *inpatient* facility, an outpatient facility or a surgical facility, including services and supplies.
2. For 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 devices* or other *necessary medical supplies* following a medical or *surgical procedure* such as crutches, orthopedic splints, braces or casts. Please see the Durable Medical Equipment provision of this *contract*.
7. For hemodialysis and the charges by a *hospital* or facility for the processing and administration of genetic testing, blood or blood components, including cost of blood, blood plasma and blood plasma expanders, which is not replaced by or for you.
8. For the cost and administration of anesthesia, oxygen, drugs, medications and biologicals.
9. For *medically necessary* dental, cosmetic, reconstructive, or plastic *surgery* because of:
    a. *Surgery* to correct a defect resulting from accidental *injury*, including but not limited to vision and dental.
    b. Damage to his or her natural teeth.
    c. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
    d. *Surgery* to correct a functional defect which results from a congenital and/or acquired disease or anomaly.
    e. 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.
    f. *Reconstructive surgery* for craniofacial abnormalities.
    g. Cleft lip and cleft palate for an *eligible child* under the age of 18. *Covered services* includes medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the treating *physician* or surgeon and such *physician* or surgeon certifies that such services are *medically necessary* and consequent to treatment of the cleft lip or cleft palate.
    h. 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 health care professional, in consultation with the dentist, determines the child 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* whose treating health care professional, in consultation with the dentist, determines the child has a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or;
        iii. A *member* who has one (1) or more medical conditions that would create significant or undue medical risk for the individual during delivery of any dental treatment or *surgery* if not rendered in a *hospital* or *ambulatory surgical center*.
10. For infertility counseling and planning services when provided by a *network provider* and testing to diagnose infertility.

11. For the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.
12. Necessary dental treatment is that which, if left untreated, is likely to result in a medical condition. Use of general anesthesia in a *hospital* or *ambulatory surgical center* is subject to *prior authorization* by us. Please call Member Services to confirm your benefits for the use of general anesthesia in a *hospital* or *ambulatory surgical center*.
13. For routine patient care for patients enrolled in an eligible cancer or life-threatening *illness*, clinical trial that is deemed an *experimental or investigational* treatment if the services provided are otherwise considered *covered services* under the *contract*. See the Clinical Trial Coverage provision of this *contract*.
14. For the following types of *medically necessary* implants and tissue grafts:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.
    e. Implantable prosthetic lenses, in connection with cataracts.
    f. Skin grafts.
15. For X-ray, Magnetic Resonance Imaging (MRI), Computed Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT), and other diagnostic services. See the Radiology, Imaging and Other Diagnostic Testing provision of this *contract*.
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. *Medically necessary* services for complications arising from medical and surgical conditions.
19. For respiratory, pulmonary, cardiac, physical, occupational, and speech therapy services. Please see the Rehabilitation and Extended care facility Expense Benefits & Habilitation Expense Benefits provisions of this contract.
20. For maternity care services including but not limited to prenatal, postnatal, diagnostic testing, laboratory services, and *hospital* services.
21. For children's early intervention therapy for expenses arising from the services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists and clinical social workers working with children from birth to 36 months of age with an identified developmental disability and/or delay.
22. *Medically necessary* footcare treatment that may require *surgery*; *prior authorization* may be required.
23. For preventive procedures that are considered medical or surgical, such as, but not limited to colonoscopy, sterilization, and cancer screenings, as follows:

a. A pelvic examination and pap smear for any non-symptomatic woman who is a *member*, in accordance with the current USPSTF/HRSA guidelines.

b. A prostate examination and laboratory tests for cancer for any non-symptomatic man who is a *member*; and

c. A colorectal cancer examination and laboratory tests for cancer for any non-symptomatic *member*, in accordance with the current USPSTF guidelines. Please see the Preventive Care Expense Benefits provision of this *contract*.

24. 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*.
25. *Medically necessary* services made by a *provider* who renders services in a *network urgent care center*, including facility costs and supplies.
26. *Medically necessary* biofeedback services.
27. For abortions performed to save the life of the *member* and performed in accordance with *applicable law*.
28. Cost for 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 procedure.
29. For *medically necessary spinal manipulation* or *manipulative therapy* treatment on an outpatient basis only. See your *Schedule of Benefits* for benefit levels or additional limits. *Covered services* are subject to all other terms and conditions of the *contract*, including the *deductible amount* and *cost sharing* provisions.
30. 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. Including, but not limited to, hearing or audiological services, follow up exams and pulse oximetry.
31. For *medically necessary* allergy testing, treatment including allergy injections and serum.
32. When deemed *medically necessary* by your *provider*, nutritional counseling is a covered benefit.
33. For *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis.

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; or
6. *Physician* to *physician* consultation.

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

Medical Vision Services

Eye examinations for the treatment of medical conditions of the eye are covered when the service is performed by a participating *network provider* (optometrist or ophthalmologist). *Covered services* include office visits, testing, and treatment of eye conditions producing symptoms that if left untreated may result in the loss of vision.

Excluded services for routine and non-routine vision include:

1. Visual Therapy.
2. Any vision services, treatment or material not specifically listed as a *covered service*.
3. Low vision services and hardware for adults; and
4. Non-network care, except when prior-authorized.

If you have elected additional Adult Vision Benefits, please refer to the Vision Benefits - Adults 19 years of age or older section of this *contract*.

Mental Health and Substance Use Disorder Benefits

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

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

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* and active treatment of *mental health disorders*, or *substance use disorders* as defined in this *contract*.

When making coverage determinations, our mental health Utilization Management staff utilizes established level of care guidelines and *medical necessity* criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. Our *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.

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

Inpatient

1. *Inpatient* psychiatric hospitalization;
2. *Inpatient* detoxification treatment;
3. Crisis stabilization;
4. *Inpatient rehabilitation*;

5. *Residential treatment facility* for mental health and *substance use disorders*; and
6. Electroconvulsive therapy (ECT).

Outpatient

1. Partial hospitalization program (PHP);
2. Intensive outpatient program (IOP);
3. Mental health day treatment;
4. Evaluation and assessment for mental health and *substance use disorder*;
5. Traditional *outpatient services*, including individual and group therapy services;
6. Medication management services;
7. Medication-assisted treatment–combines behavioral therapy and medications to treat *substance use disorders*;
8. Outpatient detoxification programs;
9. Psychological and neuropsychological testing and assessment;
10. *Applied behavior analysis*;
11. *Telehealth services*, provided on the same basis and to the same extent (including *cost share* amounts) for the provision of in-person health care services (includes individual/family therapy; medication monitoring; assessment and evaluation);
12. Electroconvulsive therapy (ECT); and
13. Transcranial magnetic stimulation (TMS).

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

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

Pap Smear Coverage

Covered services include cervical cancer screening when prescribed by your *physician* or *medical practitioner*.

Pediatric Vision 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 exam
    a. Refraction
    b. Dilation
2. Standard frames

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

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

Services not covered:

1. Visual therapy;
2. Two pair of glasses as a substitute for bifocals;
3. Non-network care without *prior authorization*; and
4. LASIK *surgery*.

Under the “Mail Order Pharmacy/Prescription Drug Delivery” section, you will find details on your in-*network* mail order pharmacies and next steps for enrollment.

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 expenses in this benefit provision are limited to charges from a licensed pharmacy for:

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

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

Covered *prescription drugs*, which are not subject to utilization management, *prior authorization*, or pre-certification requirements, and are considered maintenance, are covered up-to-90-day supply at select retail pharmacies within our *network*. Controlled substances as identified by the United States Drug Enforcement Administration are exempt from this section. The *prescription drugs* received in a 90-day supply may be subject to *copayments, coinsurance amounts, deductibles,* or other *member cost shares*.

The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her *physician*. *Experimental or investigational* treatment drugs will be covered as defined.

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

Coverage for specialty and non-specialty *prescription drugs* will be limited to a supply sufficient for 34 consecutive days of therapy based on criteria established by us, except *prescription drugs* that are considered maintenance and may be dispensed in supplies up to a maximum of 100-unit dose quantities, but not to exceed a supply sufficient for 100 consecutive days of therapy, if such is greater than a 34 consecutive day supply. The *prescription drugs* received may be subject to *copayments*, *coinsurance amounts, deductible*s, or other *member cost shares*.

Formulary or Prescription Drug List

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

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

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

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 medication(s) only at specified location. Ambetter Health pharmacy, together with Medical Management will review *member* profiles and using specific criteria, will recommend *members* for participation in lock-in program. *Members* identified for participation in the lock-in program and associated *providers* will be notified of such *member's* 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.

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 us or a protocol exception for step therapy. The request can be made in writing or via telephone. Within 72 hours of the request being received, we will provide the *member*, the *member's authorized representative* or the *member's* prescribing *physician* with our coverage determination. Should the standard exception request or step therapy protocol exception request be granted, we will provide coverage of the non-formulary drug for the duration of the prescription, including refills, or of the drug that is the subject of the protocol exception.

Expedited exception request

A *member*, a *member's authorized representative* or a *member's* prescribing *physician* may request an expedited review based on exigent circumstances. Exigent circumstances exist when a *member* is suffering from a health condition that may seriously jeopardize the *member's* life, health, or ability to regain maximum function or when a *member* is undergoing a current course of treatment using a non-formulary drug. 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 three business days following receipt of the request, if the original request was a standard exception, and no later than one business day 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.

Notice and Proof of loss:

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

Split-Fill Dispensing Program

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

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.

Non-Covered Services and Exclusions:

No benefits will be paid under this benefit provision for expenses incurred:

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance, unless listed on the formulary.
2. For immunization agents otherwise not required by the Affordable Care Act.
3. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
4. For a refill dispensed more than 12 months from the date of a *physician's* order.
5. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.

6. For a prescription order that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are listed on the formulary. This exclusion does not apply to prescribed FDA-approved contraceptive methods.
7. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
8. For any drug that we identify as therapeutic duplication through the drug *utilization review* program.
9. For more than a 34-day supply when dispensed in any one prescription or refill, or for maintenance drugs up to 90-day supply when dispensed by any retail or mail order pharmacy, or a pharmacy other than select retail or mail order that participates in extended day supply *network*. **Note:** that only the 90-day supply may be subject to the discounted *cost sharing*. Mail orders less than 90 days are subject to the standard *cost sharing* amount.
10. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
11. For foreign prescription medications, except those associated with an *emergency* medical condition while you are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this section if obtained in the United States.
12. For drugs or dosage amounts determined by Ambetter Health's Pharmacy and Therapeutics Committee to be ineffective, unproven or unsafe for the indication for which they have been prescribed, regardless of whether the drugs or dosage amounts have been approved by any governmental regulatory body for that use.
13. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
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 for out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
15. For any medications used for cosmetic purposes.
16. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status. To facilitate appropriate benefit use and prevent opioid overutilization, *member's* participation in lock-in status will be determined by review of pharmacy claims.
17. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
18. For medication refills where a *member* has more than 15 days' supply of medication on hand.
19. For weight loss *prescription drugs* unless otherwise listed on the formulary.
20. For any drug elated to dental restorative treatment or treatment of chronic periodontitis where drug administration occurs at dental practitioner's office.
21. For compound drugs, unless there is at least one ingredient that is an FDA-approved drug.
22. For any drug related to *surrogate pregnancy*.
23. For drugs that are administered or entirely used up at the time and place ordered.

24. *Prescription drugs* for which normally (in professional practice) there is no charge.
25. *Prescription drugs* for other than human use.
26. For drugs, supplies, and equipment used in intravenous treatment, except as specifically provided under the *contract*.
27. For *prescription drugs* covered under another *contract*, certificate, or rider issued by us.
28. For *prescription drugs* listed as excluded on the formulary. This is in addition to drugs or classes of drugs excluded under the other provisions of this *contract.*
29. For *prescription drugs* utilized primarily for the stimulation of hair growth. This applies for drugs that are prescribed for purposes other than the stimulation of hair growth.

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 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. 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 amount*. To enroll for mail order delivery or for any additional questions, please refer to our Ambetter Health website. Once on our Ambetter Health website, you will find details on your in-*network* mail order pharmacies and next steps for enrollment.

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 (USPTF).
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). Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.

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 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 amount* 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 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 AmbetterHealth.com or by contacting Member Services.

Prostate Specific Antigen Testing

Medically necessary, *covered services* include an annual digital rectal examination and prostate specific antigen test performed to determine the level of prostate specific antigen in the blood. 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 your *Schedule of Benefits* for details.

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

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

Second Medical Opinion

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

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

If requested, the second opinion consultation is to be provided by a *network physician* of the *member's* choice. If a *member* chooses a *network physician*, he or she will only be responsible for the applicable *cost sharing* for the consultation; however, any laboratory tests and/or diagnostic and therapeutic services are subject to the additional *cost sharing*. If a *member* selects a *non-network physician*, the services are not covered, and the *member* is responsible for payment of all services and items.

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.

Spinal Manipulation Services

We cover *medically necessary spinal manipulation* services on an outpatient basis. See the *Schedule of Benefits* for applicable *cost share* and limits.

Transplant Service Expense Benefits

Covered services for transplant expenses:

Transplants are a *covered service* when a *member* is accepted as a transplant candidate and pre-authorized in accordance with this *contract*. *Prior authorization* must be obtained through the "*Center of Excellence*" 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 be provided by a *network provider* and facility, and meet other medical criteria as set by medical management policy and the medical *providers* performing the transplant.

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

1. If both the donor and recipient have coverage provided by the same insurer each will have their benefits paid by their own coverage program.

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

If we determine that a *member* is an appropriate candidate for a *medically necessary* transplant, covered expenses will be for:

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

Please refer to the "Member Transplant Travel Reimbursement Policy" for outlined details on reimbursement limitations AmbetterHealth.com.

Ancillary "Center of Excellence" Benefits

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

1. We will pay for the following services when the *member* is required to travel more than 60 miles from the *residence* to the *Center of Excellence*.
2. We will pay a maximum of $10,000 per transplant service for the following services:
    a. Transportation for the *member*, any live donor, and the companion(s) to accompany the *member* to and from the *Center of Excellence*.

b. 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*. 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 six months of the date of service in order to be reimbursed.

c. When *member* and/or donor is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.

d. 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.

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

Exclusions:

No benefits will be paid under these Transplant Expense Benefits for charges:

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *medically necessary* transplant occurs;
2. For animal to human transplants;
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the *Center of Excellence*;
4. To keep a donor alive for the transplant operation;
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ;
6. Related to transplants unauthorized through the *Center of Excellence* and not included under this provision as a *medically necessary* transplant;
7. For a *medically necessary* transplant under study in an ongoing phase I or II clinical trial as set forth in FDA regulation, regardless of whether the trial is subject to FDA oversight. **Note:** This exclusion does not apply to bone marrow transplants;
8. The acquisition cost for the organ or bone marrow when provided at an *authorized facility* or not obtained through the *Center of Excellence*;
9. For any transplant services and/or travel related expenses for *member* and donor when performed outside of the United States;
10. The following ancillary items listed below will not be subject to the *member* reimbursement under this *contract*:

    a. Alcohol/tobacco

    b. Car, trailer or truck rental (unless pre-approved by Case Management)

c. Vehicle maintenance for motorized and hybrid and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.)
d. Parking, (unless 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 violations, tickets or parking tickets
j. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
k. For any services related to pet care, boarding, lodging, food, and/or travel expenses
l. Expenses for persons other than the transplant recipient, donor or their respective companion(s)
m. Expenses for lodging when the transplant recipient, donor or their respective companion(s) are staying with a relative, friend or otherwise have free lodging
n. Any expense not supported by a receipt
o. Upgrades to first class travel (air, bus, and train)
p. Personal care items (e.g., shampoo, deodorant, clothes)
q. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA pre-check, and early check-in boarding fees, extra baggage fees
r. Souvenirs (e.g., t-shirts, sweatshirts, toys)
s. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type
t. All other items not described in the *contract* as *eligible expenses*
u. Any fuel costs/charging station fees for any vehicle (but note that mileage is reimbursable)
v. Any tips, concierge, club level floors, and gratuities
w. Salon, barber, and spa services
x. Insurance premiums
y. *Cost share* amounts owed to the transplant surgeon or facility or other *provider*.

Limitations on Transplant Expenses Benefits:

In addition to the exclusions and limitations specified elsewhere in this section, if a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Urgent Care Service Benefits

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

Members are encouraged to contact their *PCP* for an appointment before seeking care from another *provider*, but contracted *urgent care 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 1-833-543-3145 (TTY 711). The 24/7 Nurse Advice Line is available 24 hours a day, 7 days a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

Vision Benefits – Adults 19 years of age or older

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

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

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

Services not covered:

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

WELLNESS PROGRAMS AND OTHER OFFERINGS

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

The Ambetter Health preventive care and wellness program includes offerings for health check-ups, screenings for common conditions and vaccinations. Rewards, 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 Health 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 *contract*, 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 *deductible*s, *copayments*, and *coinsurance amounts* 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.

PRIOR AUTHORIZATION

Ambetter Health 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 Health.
2. Concurrent review – occurs when a medical service is reviewed as they happen (e.g., *inpatient* stay or *hospital* admission).
3. Retrospective review – occurs after a service has already been provided.

Prior Authorization Required

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

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

1. Receives a service or supply from a *non-network provider*;
2. Is admitted into a *network* facility by a *non-network provider*; or
3. Receives a service or supply from a *network provider* to which the *member* was referred by a *non-network provider*.

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

Prior authorization requests (medical and *behavioral health*) must be received by telephone, eFax, or *provider* web portal as follows:

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

Prior authorization must be obtained for the following services, except for urgent care or *emergency services*. This list is not exhaustive, to confirm if a specific service requires *prior authorization*, please contact Member Services.

1. Non-emergency health care services provided by *non-network providers*;
2. Reconstructive procedures;
3. Diagnostic tests such as specialized labs, procedures and high technology imaging;
4. Injectable drugs and medications;
5. *Inpatient* health care services;

6. Specific *surgical procedures*;
7. Nutritional supplements;
8. Pain management services; and
9. Transplant services.

After *prior authorization* has been 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 request.
2. For urgent pre-service reviews, within 72 hours of receipt of request.
3. For non-urgent pre-service reviews within 15 calendar days of receipt of all information necessary to make a determination.
4. For post-service or retrospective reviews, within 30 calendar days of receipt.

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

Except for medical emergencies, *prior authorization* must be obtained before services are rendered or expenses are incurred.

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

How to Obtain Prior Authorization

To obtain *prior authorization* or to confirm that a *network provider* has obtained *prior authorization*, contact 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. Please see your *Schedule of Benefits* for specific details.

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

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

Prior Authorization Does Not Guarantee Benefits

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

Requests for Predeterminations

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

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

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

Services from Non-Network Providers

Except when *balance billing protections* apply to a *covered service* provided by a *non-network provider*, we do not normally cover services received from *non-network providers*. If a situation arises where 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 the *provider* must request *prior authorization* from us before you may receive services from *non-network providers*. Otherwise, you will be responsible for all charges incurred.

GENERAL LIMITATIONS AND EXCLUSIONS

No benefits will be paid for:

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

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

1. Administered or ordered by a *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 expenses will not include, and no benefits will be paid for any charges that are incurred:

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*;
2. For any portion of the charges that are in excess of the *eligible expense*;
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*; and bariatric *surgery* except as specifically covered in the Major Medical Expense Benefits section of this *contract*;
4. For weight loss programs, gym memberships, exercise equipment, or meal preparation programs;
5. For cosmetic breast reduction or augmentation except for the *medically necessary* treatment of gender dysphoria;
6. For reversal of sterilization and vasectomies;
7. For abortions, unless performed to save the life of the *member* and not illegal under *applicable law*;
8. For artificial insemination (AI), assisted reproductive technology (ART) procedures or the diagnostic tests and drugs to support AI or ART procedures;
9. For expenses for television, telephone, or expenses for other persons;
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions;
11. For telephone consultations between *providers*, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment;

12. For stand-by availability of a *medical practitioner* when no treatment is rendered;
13. For *dental expenses*, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under the Medical Benefits section;
14. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect;
15. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant 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 by the *contract*;
18. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*;
19. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the *contract*;
20. For hearing aids, except as specifically provided under the *contract*;
21. For *experimental or investigational* treatment(s) or *unproven services,* except as specifically provided under the *contract*. 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 procedures and diagnostic tests that are considered to be obsolete by a professional medical-advisory committee;
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 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. As a result of an *injury* or disease arising out of, or in the course of, acts of war, insurrection, rebellion, armed invasion or aggression;
25. For or related to *surrogate* parenting;
26. For fetal reduction *surgery*;
27. Except as specifically identified as a covered expense under the *contract*, expenses for alternative treatments, including acupressure, aromatherapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health;

28. For the following miscellaneous items: home test kits, unless required by *applicable law*; care or services provided to a non-member biological parent; nutrition or dietary supplements; pre-marital laboratory 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 *contract*. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment;
29. For services or supplies eligible for payment under either federal or state programs (except Medicaid). This exclusion applies whether or not you assert your rights to obtain this coverage or payment of these services;
30. For mental health services for the following:
    a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless a plan *physician* determines such evaluation to be *medically necessary*;
    b. When ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless a plan *physician* determines such services to be *medically necessary*;
    c. Court-ordered testing and testing for ability, aptitude, intelligence or interest;
    d. For services associated with any mass screening type of physical or health examinations except for pap smears and mammograms performed at a mobile facility certified by the Centers for Medicare and Medicaid Services (e.g., mass screenings at mobile vans and school testing programs).
31. *Surrogacy arrangement*. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a *member*. 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 *contract* with us effective at the time of birth.
32. For any medicinal and recreational use of cannabis or marijuana;
33. For all health care services obtained at an urgent care facility that is a *non-network provider*;

34. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Medical and Surgical Expense Benefits provision;
35. 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;
36. For any product that reasonably could be expected to be non-self-administered or for products that should be administered in a medical facility;
37. For immunizations that are not *medically necessary* or medically indicated. This includes those used for travel and occupational uses;
38. For expenses, services, and treatments from a massage therapist to touch and manipulate the muscles and other soft tissues of the body;
39. 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;
40. For expenses, services, and treatments from a naturopathic specialists for treatment of prevention, self-healing and use of natural therapies;
41. For expenses, services, and treatments related to private duty nursing in an *inpatient* location;
42. For expenses or services related to dry needling;
43. For expenses related to autopsies, unless the autopsy is requested by us;
44. For diagnostic tests and evaluations that are ordered, requested or performed solely for the purpose of resolving issues in the context of legal proceedings. This includes issues concerning custody, visitation, termination of parental rights, civil damages or criminal actions;
45. For services of volunteers;
46. For prostheses that require surgical insertion into the body and billed by an entity or person that is not the *hospital* or *ambulatory surgical center* where the *surgery* was performed;
47. For expenses, services, and treatments related to autogenic biofeedback;
48. For adult eye examinations to determine the need for vision correction, unless the services are used for the treatment of diabetes;
49. For charges for completion of insurance claim forms;
50. For laboratory services performed by an independent laboratory that is not approved by Medicare;
51. For travel expenses, mileage, time spent traveling, telephone calls, charges for services provided over the telephone, services provided through e-mail or electronic communications;
52. For vehicle installations or modifications which may include, but are not limited to, adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices;
53. For assertive Community Treatment.

TERMINATION

Termination of Contract

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

1. Nonpayment of premiums when due, subject to the grace period provision in this *contract*.
2. The date we receive a request from you to terminate this *contract*, or any later date stated in your request.
3. For a covered *eligible child* reaching the limiting age of 26, coverage under this *contract* will terminate at 11:59 p.m. on the last calendar day of the year in which the covered *eligible child* turns age 26.
4. The date we decline to renew this *contract*, as stated in the Discontinuance provision.
5. The date of your death, if you are the only *member* on this *contract*.
6. The date your eligibility for insurance under this *contract* ceases due to any of the reasons stated in the Eligibility and Enrollment section in this *contract*.

If there are other *members* covered under this *contract*, it may be continued after your death:

1. By your *spouse*, if a *member*; otherwise
2. By the youngest child who is a *member*.

This *contract* will be changed, and your *spouse* or youngest child will replace you as the primary *subscriber*. A proper adjustment will be made in the premium required for this *contract* to be continued. We will also refund any premium paid and not earned due to your death. The refund will be based on a pro-rata basis.

Cancellation by Insured

You may cancel this *contract* at any time by written notice delivered or mailed to the entity through which you enrolled, effective upon receipt of such notice or on such later date as may be specified in such notice. In the event of cancellation, termination or death of the insured, we will promptly return the unearned portion of any premium paid back to the original method of payment and/or payor. 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 cancellation.

Discontinuance

90-Day Notice:

If we discontinue offering 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. 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 *contract*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180-Day Notice:

If we discontinue offering all individual policies/certificates 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.

Notification Requirements

It is the responsibility of you or your former *spouse* to notify us within 31 calendar days of your legal divorce.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its *contract* terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans does not exceed 100 percent of the total allowable expense.

Definitions

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

Plan includes:

1. Group insurance *contracts* and *subscriber contracts*;
2. Uninsured arrangements of group or group-type coverage;
3. Group coverage through closed panel plans;
4. Group-type *contracts*;
5. The medical care components of long-term care *contracts*, such as skilled nursing care;
6. Medicare or other governmental benefits, as permitted by law, except as provided in paragraph (4) (h) of this section. That part of the definition of plan may be limited to the *hospital*, medical and surgical benefits of the governmental program;
7. Group and nongroup insurance *contracts* and *subscriber contracts* that pay or reimburse for the cost of dental care;
8. Nongroup insurance *contracts* issued on or after January 1, 2014;
9. Nongroup coverage through closed panel plans issued on or after January 1, 2014.

Plan does not include:

1. *Hospital* indemnity coverage benefits or other fixed indemnity coverage;
2. Accident only coverage;
3. Specified disease or specified accident coverage;
4. Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, *respite care* and *custodial care* or for *contracts* that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
5. Medicare supplement policies;
6. A state plan under Medicaid; or
7. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

1. This plan means, in a COB provision, the part of the *contract* providing the health care benefits to which the COB provision applies, and which may be reduced because of the benefits of *other plans*. Any other part of the *contract* providing health care benefits is separate from this plan. A *contract* may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
2. The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.
    a. When this plan is primary, it determines payment for its benefits first before those of any *other plan* without considering any *other plan's* benefits.
    b. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100 percent of the total allowable expense.
3. Allowable expense is a health care expense, including *deductibles*, *coinsurance amounts* and *copayments*, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a *provider* by law or in accordance with a contractual agreement is prohibited from charging a *member* is not an allowable expense.
4. The following are examples of expenses that are not allowable expenses:
    a. The difference between the cost of a semi-private *hospital* room and a private *hospital* room is not an allowable expense, unless one of the plans provides coverage for private *hospital* room expenses.
    b. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
    c. The amount of any benefit reduction by the primary plan because a *member* has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred *provider* arrangements.
5. Closed panel plan is a plan that provides health care benefits to *members* primarily in the form of services through a panel of *providers* that have contracted with or are employed by the plan, and that excludes coverage for services provided by other *providers*, except in cases of *emergency* or referral by a panel member.
6. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any *other plan*.

B. (1) Except as provided in paragraph B (2) a plan that does not contain a coordination of benefits provision that is consistent with K.A.R. 40-4-34 is always primary unless the provisions of both plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the *contract* holder. These types of situations include major medical coverages that are superimposed over base plan *hospital* and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that *other plan*.

D. Each plan determines its order of benefits using the first of the following rules that apply:

1. Non-dependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, *member*, policyholder, *subscriber* or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, *member*, policyholder, *subscriber* or retiree is the secondary plan and the *other plan* is the primary plan.

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

a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

i. The plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

ii. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child’s health care expenses, but that parent’s *spouse* does, that parent’s *spouse’s* plan is the primary plan. This rule applies to plan years commencing after the plan is given notice of the court decree;

ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of paragraph D (2)(a) above shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph D(2)(a) above shall determine the order of benefits; or

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

a. The plan covering the custodial parent;

b. The plan covering the *spouse* of the custodial parent;

c. The plan covering the non-custodial parent; and then;

d. The plan covering the *spouse* of the non-custodial parent.

c. For a dependent child covered under more than one plan of individuals who are the parents of the child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

i. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a *spouse's* plan, the rule in subsection D(5) within this section applies.

ii. In the event the dependent child's coverage under the *spouse's* plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subsection D(2)(a) to the dependent child's parent(s) and the dependent's *spouse*.

3. Active Employee or Retired or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the *other plan* does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, *member*, *subscriber* or retiree or covering the person as a dependent of an employee, *member*, *subscriber* or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the *other plan* does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.

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

6. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of this Plan

1. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the Primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan *deductible* any amounts it would have credited to its *deductible* in the absence of other health care coverage.
2. If a *member* is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel *provider*, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.
3. If this plan is secondary to Medicare, it may reduce its benefits so that the total benefits paid are reduced to Medicare's allowable amount, subject to our plan limits.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and *other plans*. Ambetter Health or its designated COB administrator may get the facts it needs 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. Ambetter Health or its designated COB administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give Ambetter Health or its designated COB administrator any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, Ambetter Health or its designated COB administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Ambetter Health or its designated COB administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

Ambetter Health has the right and responsibility to correct benefit payment errors as required by K.S.A. 40-2442.

Errors Related to Your Coverage.

Ambetter Health has the right to correct benefit payments that are made in error. *Providers* and/or you have the responsibility to return any overpayments to us. We have the responsibility to make additional payments if any underpayments have been made.

CLAIMS

Notice of Claim

Written notice of claim must be given to the insurer within 20 calendar days after the occurrence or commencement of any *loss* covered by the *contract*, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the *member* or the beneficiary should be sent to the insurer at Ambetter Health, P.O. Box 5010, Farmington, MO 63640-5010, or to any *authorized* agent of the insurer, with information sufficient to identify the *member*, shall be deemed notice to the insurer.

Claim Forms

Upon receipt of a notice of claim, we will furnish to the *claimant* such forms as are usually furnished by us for filing proofs of *loss*. If such forms are not furnished within 15 calendar days after the giving of such notice you shall be deemed to have complied with the requirements of this *contract* as to *proof of loss* upon submitting, within the time fixed in the *contract* for filing proofs of *loss*, written proof covering the occurrence, the character and the extent of the *loss* for which claim is made.

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 after the date of *loss* will not be accepted, unless you or your *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. We can adjust your *deductible*, *copayment amount* or *cost sharing* to reimburse you.

To request reimbursement for a *covered service*, you need a copy of the detailed claim from your *provider*. You will also need to submit a copy of the *member* reimbursement claim form posted at AmbetterHealth.com. 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 *contract* and as often as may be reasonably necessary:

1. Sign, date and deliver to us *authorizations* to obtain any medical or other information, records or documents we deem relevant from any person or entity;
2. Obtain and furnish to us, or our representatives, any medical or other information, records or documents we deem relevant;

3. Answer, under oath or otherwise, any questions we deem relevant, which we or our representatives may ask; and
4. Furnish any other information, aid or assistance that we may require, including without limitation, assistance in communicating with any person or entity including requesting any person or entity to promptly provide to us, or our representative, any information, records or documents requested by us.

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

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

Timely Payment of Claims

Indemnities payable under this *contract* for any *loss* other than *loss* for which this *contract* provides any periodic payment will be paid immediately upon receipt of due written proof of such *loss*. Subject to due written *proof of loss*, all accrued indemnities for *loss* for which this *contract* provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims

Benefits are paid to the *member* within 30 calendar days after receipt of a clean non-electronic claim or 15 calendar days upon receipt of a clean electronic claim.

If Ambetter Health is denying or pending the claim, Ambetter Health shall have 15 calendar days upon receipt of an electronic claim or 30 calendar days upon receipt of a non-electronic claim to notify the health care *provider* or *member* of the reason for denying or pending the claim and what, if any, additional information is required to adjudicate the claim. Upon Ambetter Health receipt of the requested additional information, Ambetter Health shall adjudicate the claim within 15 calendar days. If the required notice is not provided, the claim shall be treated as a clean claim and shall be adjudicated.

Any claim not paid within the time periods specified shall be deemed overdue. When a claim is overdue, the health care *provider* may notify Ambetter Health in writing of Ambetter Health noncompliance. If we fail to pay the claim within the allotted time, then:

1. The amount of the overdue claim shall include an interest payment of 1 percent per month beginning from the date the payment was due; and
2. The health care *provider* may recover from Ambetter Health, upon a judicial finding of bad faith, reasonable attorney's fees for advising and representing a health care *provider* in a successful action against us for payment of the claim.

Indemnity for *loss* of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the *member*. Any other accrued indemnities unpaid at the *member's* death, at the option of the insurer, may be paid either to such beneficiary or to such estate. All other indemnities will be payable to the *member*.

Claims Incurred for Emergency Services While Traveling Outside the United States

Medical *emergency services* are covered for up to 90 consecutive days while traveling outside 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 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.

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.

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 *contract* except for the right to receive benefits, if any, that we have determined to be due and payable.

Medicaid Reimbursement

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

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

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

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

Custodial Parent

This provision applies if the parents of a covered *eligible child* are divorced or legally separated, and both the custodial parent and the non-custodial parent are subject to the same court or administrative

order establishing custody. The custodial parent, who is not a *member*, will have the rights stated below if we receive a copy of the order establishing custody.

Upon request by the custodial parent, we will:

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

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

Physical Examination

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

Legal Actions

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

Non-Assignment

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

No Third-Party Beneficiaries

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

GRIEVANCE AND APPEAL PROCEDURES

Internal Procedures

Applicability/Eligibility

The internal *appeal* and *grievance* procedures apply to any *hospital* or medical policy or certificate.

An eligible appellant/grievant is:

1. A *claimant*;
2. In the event the *claimant* is unable to give consent: a *spouse*, family member, or the treating *provider*.

Claimant means the *member* or *member's authorized representative* who has contacted the plan to file a *grievance* or who has contacted the Kansas Department of Insurance to file an external review.

Grievances

Basic elements of a *grievance* include:

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

*Claimant*s have the right to submit written comments, documents, records, and other information relating to the *grievance*. *Claimants* have the right to present evidence and testimony as part of the internal review process.

Claimants should submit all documentation to us at:

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

If your *appeal* is related to *behavioral health* services, you may request an *appeal* by mailing your request to us at:

Ambetter Health
Attn: Appeals & Grievances Department
P.O. Box 10378
Van Nuys, CA 91410-0378

Grievance Timeframes

Within five business days of receipt of a *grievance*, a written acknowledgment to the *claimant* or the *claimant's authorized representative* confirming receipt of the *grievance* will be delivered or deposited in the mail.

Grievances will be promptly investigated and will be resolved within 20 business days of receipt. The time period for investigation may be extended for a period of an additional 14 calendar days at a time. If we make use of such extensions, we must provide the *claimant* or the *claimant's authorized representative*, if applicable, written notification of the following within the first 20 business days:

1. That we have not resolved the *grievance*;
2. When our resolution of the *grievance* may be expected; and
3. The reason why the additional time is needed.

Written Grievance Response

Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the *grievance* resolution.

The written decision to the grievant must include:

1. The disposition of and the specific reason or reasons for the decision.
2. Any corrective action taken on the *grievance*.

Complaints Received from the State Insurance Department

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

Appeals

An *appeal* is a request to reconsider a decision about the *claimant's* benefits where either a service or claim has been denied.

Claimants have the right to submit written comments, documents, records, and other information relating to the claim for benefits. *Claimants* have the right to review the claim file and to present evidence and testimony as part of the internal review process. A *claimant* may request an *appeal* within 180 calendar days of the *adverse benefit determination*.

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

Acknowledgement

Within five business days of receipt of an *appeal*, a written acknowledgment to the *claimant* or the *claimant's authorized representative* confirming receipt of the *appeal* will 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 health care information or medical records may be disclosed only if permitted by law.

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

Resolution Timeframes

All *appeals* will be resolved, and we will notify the *claimant* in writing with the *appeal* decision within the following timeframes:

1. *Post-service claim*: within 30 calendar days after receipt of the *claimant's* request for internal *appeal*.
2. *Pre-service claim*: within 15 business days after receipt of the *claimant's* request for internal *appeal*.

Ambetter Health may extend the resolution timeframe by 14 calendar days if the following conditions are met:

1. The *member* requests an extension or
2. The *member* voluntarily agrees to extend the *appeal* time frame.

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

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

Expedited Appeal

An expedited *appeal* may be submitted orally or in writing. All necessary information, including our determination on review, will be transmitted between the *claimant* and us by telephone, facsimile, or

other available similarly expeditious method. The plan will issue an *appeal* resolution letter and notify the *member* or *authorized representative* of the right to access expedited external review from the Kansas Insurance Commissioner.

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

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

Ambetter Health may extend the resolution timeframe by 14 calendar days if the following conditions are met:

1. The *member* requests an extension; or
2. The *member* voluntarily agrees to extend the *appeal* timeframe.

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

Written Appeal Response

Appeal response letters shall describe, in detail, the *appeal* procedure and the notification shall include the specific reason for the denial, determination or initiation of disenrollment.

The written decision to the appellant must include:

1. The disposition of and the specific reason or reasons for the decision;
2. If upheld or partially upheld, it is also necessary to include:
    a. A clear explanation of the decision;
    b. Reference to the specific plan provision on which the determination is based;
    c. A statement that the *claimant* is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *claimant 's* claim for benefits;
    d. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the *claimant* upon request;
    e. If the *adverse benefit determination* is based on a *medical necessity* or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the *claimant 's* medical circumstances, or a statement that such explanation will be provided free of charge upon request.;
    f. Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse benefit determination*;
    g. The date of service;
    h. The health care *provider's* name;

i. The health plan's denial code with corresponding meaning (applicable only to post-service *appeals*);

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

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

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

m. A copy of the form that authorizes the health plan to disclose protected health information, if applicable;

n. That assistance is available by contacting the specific state's consumer assistance department, if applicable; and

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

External Review

An external review decision is binding on us. An external review decision is binding on the *claimant* except to the extent the *claimant* has other remedies available under *applicable law*.

We will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility

The external review procedures apply to any *hospital* or medical policy or certificate.

After exhausting the internal review process, the *claimant* has 120 calendar days to make a written request to the Kansas Insurance Commissioner for external review after the date of receipt of our internal response.

1. The internal *appeal* process must be exhausted before the *claimant* may request an external review unless the *claimant* files a request for an expedited external review at the same time as an internal expedited *appeal* or we either provide a waiver of this requirement or fail to follow the *appeal* process;
2. A health plan must allow a *claimant* to make a request for an expedited external review at the time the *claimant* receives:
    a. An *adverse benefit determination* if the determination involves a medical condition of the *claimant* for which the timeframe for completion of an internal expedited *appeal* would seriously jeopardize the life or health of the *claimant* or would jeopardize the *claimant's* ability to regain maximum function or would subject the *member* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *appeal*, and the *claimant* has filed a request for an internal expedited *appeal*; and
    b. A final internal *adverse benefit determination*, if the *claimant* has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the *claimant* or would jeopardize the *claimant's* ability to regain maximum function or would subject the *member* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *appeal*, or if the final internal *adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service for which the *claimant* received *emergency services*, but has not been discharged from a facility; and

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

External review is available for *appeals* that involve:

1. Medical judgment, including but not limited to those based upon requirements for *medical necessity*, appropriateness, health care setting, level of care or effectiveness of a *covered service*; or the determination that a treatment is *experimental or investigational*, as determined by an external reviewer; or
2. A determination of whether *balance billing protections* apply and the *member cost-sharing* that applies for services subject to *balance billing protections.*

External Review Process

1. The Kansas Insurance Commissioner has 10 business days (immediately for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether:
   a. The individual was a *member* at the time the item or service was requested;
   b. The service is a *covered service* under the *claimant's* health plan but for the plan's *adverse benefit determination* with regard to *medical necessity experimental/investigational*, or medical judgment;
   c. The *claimant* has exhausted the internal process; and
   d. The *claimant* has provided all of the information required to process an external review.
2. Within 10 business days (immediately for expedited) after receiving the request for external review, the Kansas Insurance Commissioner will notify the *claimant* in writing as to whether the request is complete and accepted, complete but not eligible for external review and the reasons for its ineligibility or, if the request is not complete, the additional information needed to make the request complete.
3. The Kansas Insurance Commissioner will assign an Independent Review Organization (IRO) to conduct the external review;
4. Within five business days after the date of assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the Kansas Department of Insurance, who will provide the information to the IRO.

   Note: For expedited, after assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the Kansas Department of Insurance electronically or by telephone or facsimile or any other available expeditious method;
5. If we fail to timely provide the documents and information, the Kansas Department of Insurance may terminate the external review and make a decision to reverse the *adverse benefit determination*;
6. The Kansas Insurance Commissioner will timely notify the *claimant* in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the *claimant* may within seven business days after the receipt of the notice, provide the Kansas Department of Insurance with additional documents and information that the person wants the assigned external review organization to consider in making its decision;

7. Upon receipt of the information, we may reconsider our determination. If we reverse our *adverse benefit determination*, we must provide written notice of the decision to the *claimant*, the Kansas Insurance Commissioner, and the IRO immediately after making such decision. The external review would be considered terminated;
8. Within 30 business days (not more than 72 hours for expedited) after the date of receipt of the request for an external review, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to the *claimant*, the Kansas Insurance Commissioner, and to us;
9. Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, we will approve the *covered service* that was the subject of the *adverse benefit determination*.

Requests for an External Review should be submitted to:

Kansas Department of Insurance
1300 SW Arrowhead Rd.
Topeka, KS 66604-4073
(785) 296-3071 or (800) 432-2484
Website: https://insurance.kansas.gov/complaint/
or email: KDOI.Complaints@ks.gov

Appeals and Grievances Filing and Key Communication Timelines

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard Grievance	N/A	5 Business Days	20 Business Days	14 Calendar Days
Standard Pre-Service Appeal	180 Calendar Days	5 Business Days	14 Calendar Days	14 Calendar Days
Expedited Pre-Service Appeal	180 Calendar Days	N/A	72 Hours	14 Calendar Days
Standard Post-Service Appeal	180 Calendar Days	5 Business Days	30 Calendar Days	14 Calendar Days
External Review	120 Calendar Days	N/A	30 Business Days	N/A
Expedited External Review	120 Calendar Days	N/A	72 Hours	N/A

GENERAL PROVISIONS

Entire Contract

This *contract*, with the application is the entire *contract* between you and us. No agent may:

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

Non-Waiver

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

Rescissions

No misrepresentation of fact made regarding a *member* during the application process that relates to insurability will be used to void/rescind the insurance 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 insured under the *contract*, if a *member* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *contract* or in filing a claim for *contract* benefits, we have the right to demand that *member* pay back to us all benefits that we paid during the time the *member* was insured under the *contract*.

Time Limit on Certain Defenses

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

No claim for *loss* incurred commencing after the date of issue of this *contract* shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of *loss* had existed prior to the *effective date* of this *contract*.

Conformity with State Laws

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

Personal Health Information (PHI)

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

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

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

Language Assistance

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