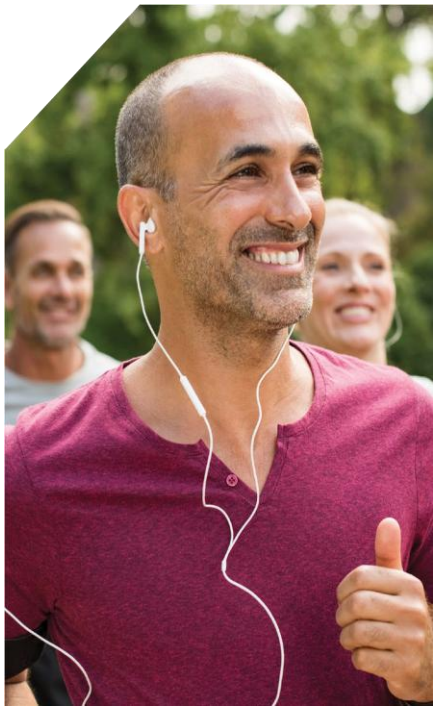
ambetter of Illinois | Insured by Celtic Insurance Company



2026 EVIDENCE OF COVERAGE

AmbetterHealth.com/en/IL

Ambetter of Illinois insured by Celtic Insurance Company

EVIDENCE OF COVERAGE

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

Individual Member HMO Contract

In this *contract*, the terms "you" or "your" will refer to the *member* or any *dependent members* enrolled in this *contract*. The terms "we," "our," or "us" will refer to Ambetter of Illinois insured by Celtic Insurance Company.

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

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

Annually, we will 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 policy plan, and age of *member*s, type and level of benefits, and place of *residence* on the premium due date are some of the factors used in determining your premium rates. We have the right to change premiums after filing and approval by the state.

At least a 31-day notice of any plan to take an action or make a change permitted by this clause will be delivered to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under this *contract* or a change in a *member*'s health. While this *contract* is in force, we will not restrict coverage already in force. If we discontinue offering and decide not to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 90 calendar days prior to the date that we discontinue coverage.

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

RIGHT TO RETURN CONTRACT

Please read your *contract* carefully. If you are not satisfied, return this *contract* to us or to our agent within 10 calendar days after you receive it. All premiums paid will be refunded, less claims paid, back to the original method of payment and/or payor. The *contract* will be considered null and void from the *effective date*. If the open enrollment or special enrollment period has expired at the time the *contract* is returned; you will not be able to purchase another policy until the next open enrollment or special enrollment period.

Ambetter of Illinois insured by Celtic Insurance Company

Kevin J. Counihan
CEO – Celtic Insurance Company

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INTRODUCTION

Welcome to Ambetter of Illinois insured by Celtic Insurance Company. 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 care services we cover.
3. The portion of your health care costs you will be required to pay.

This *contract*, the *Schedule of Benefits*, and application 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 for you in the Definitions section. This *contract* also contains exclusions, so please be sure to read this entire *contract* carefully.

Throughout this *contract* you will also see references for Celtic Insurance Company and Ambetter of Illinois. Both references are correct, as Ambetter of Illinois operates under its legal entity, Celtic Insurance Company.

How to Contact Us:
Ambetter of Illinois
P.O. Box 733
Elk Grove Village, IL 60009-0733

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

Member Services:..... 1-855-745-5507
TTY line: 1-844-517-3431
Fax:..... 1-855-519-5699
Emergency: 911
Suicide and Crisis Lifeline: 988 (call or text)
24/7 Nurse Advice Line:.... 1-855-745-5507

Interpreter Services

Ambetter of Illinois insured by Celtic Insurance Company has a free service to help our *member*s who speak languages other than English. These services ensure 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 medical interpreters to assist with languages other than English via telephone. *Member*s 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, your *physician* and *medical practitioner*s.
3. Providing information to help you become an informed health care consumer.
4. Providing access to *covered services* and our *network provider*s.
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. *Physician*s within our network may be affiliated with different *hospitals*. Our online directory can provide you with information for the *hospitals* that are contracted with us. The online directory also lists affiliations that your provider may have with non-contracted *hospitals*. Your Ambetter coverage requires you to use contracted providers with limited exceptions. You can access the online directory at www.AmbetterHealth.com/en/IL.

You have the right to:

1. Participate with your *physician* and *medical practitioner*s 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 *physician*s, *medical practitioner*s, *hospitals*, and other facilities, and your rights and responsibilities.

7. Candidly discuss with your *physician* and *medical practitioner*s 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. Make recommendations regarding *members'* rights, responsibilities and policies.
9. Voice *complaints* or *appeals* about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
10. See your medical records.
11. Be kept informed of covered and non-covered services, program changes, how to access services, *PCP* assignment, providers, advance directive information, referrals and *authorizations*, benefit denials, *member* rights and responsibilities, and our other rules and guidelines. We will notify you at least 60 calendar days before the *effective date* of the modifications. Such notices shall include the following:
    a. Any changes in clinical review criteria
    b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
12. A current list of *network provider*s.
13. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
14. Adequate access to qualified *medical practitioner*s 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.
15. Access *medically necessary* urgent and *emergency services* 24 hours a day and seven days a week.
16. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.
17. Refuse treatment to the extent the law allows without jeopardizing future treatment and be informed by your provider(s) of the medical consequence. 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.
18. Select your *PCP* within the network. You also have the right to change your *PCP* or request information on *network provider*s close to your home or work.

19. Know the name and job title of people giving you care. You also have the right to know which *physician* is your *PCP*.
20. An interpreter when you do not speak or understand the language of the area.
21. A second opinion by a *network provider*, if you want more information about your treatment or would like to explore additional treatment options.
22. Determine what actions should be taken regarding your health if you are no longer able to make decisions for yourself because of *illness* or because you are incapacitated. You have the right to have your wishes known by completing advance directive forms. Advance directive forms are forms you can complete to protect your rights for medical care. It can help your *PCP* and other providers understand your wishes about your health. Advance directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself. Examples of advance directives include:
    1. Living Will
    2. Health Care Power of Attorney
    3. "Do Not Resuscitate" orders.

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

You have the responsibility to:

1. Read this entire *contract*.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about your health that we or your *medical practitioner*s need in order to provide care. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your *physician* until you understand the care you are receiving.
4. Review and understand the information you receive about us. You need to know the proper use of *covered services*.
5. Show your *member* identification card and keep scheduled appointments with your *physician* and call the *physician*'s office during office hours whenever possible if you have a delay or cancellation.
6. Know the name of your assigned *PCP*. You should establish a relationship with your *physician*. You may change your *PCP* verbally or in writing by contacting our Member Services Department.
7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
8. Follow the treatment plans and instructions for care that you have agreed on with your health care professionals and *physician*.

9. Tell your health care professional and *physician* if you do not understand your treatment plan or what is expected of you. You should work with your *PCP* to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.
10. Follow all health benefit plan guidelines, provisions, policies and procedures.
11. Use any emergency room only when you think you have a medical emergency. For all other care, you should call your *PCP*.
12. When you enroll in this coverage, give all information about any other medical coverage you have. If, at any time, you get other medical coverage besides this coverage, you must tell 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 from the date of the event. Enrollment related changes include the following: birth of a child, or adoption, marriage, divorce, adding/removing a *dependent member*, *spouse*/domestic partner becomes eligible under a different insurer, enrollment changes, or incarceration where *member cost share* would need to transfer from one *contract* to another *contract*.

IMPORTANT INFORMATION

Provider Directory

A listing of *network provider*s is available online at AmbetterHealth.com/en/IL. We have network *physician*s, *hospitals*, and other *medical practitioner*s who have agreed to provide you with your health care services. You may find any of our *network provider*s by accessing the "Find a Doctor" page on our website and selecting the 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 copy of the provider directory at no charge by calling Member Services. In order to obtain benefits, you must designate a network *primary care physician (PCP)* for each *member*. We can help you pick a *PCP*. We can make your choice of *PCP* effective on the next business day.

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

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

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

Member Identification Card

We will mail a *member* identification card after we receive your completed enrollment materials and you have paid your initial premium payment. This card is proof that you are enrolled in an Ambetter of Illinois insured by Celtic Insurance Company 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, 24 hours a day, seven days a week. We will send you another card. A temporary identification card can be downloaded from AmbetterHealth.com/en/IL.

Website

Our website can answer many of your frequently asked questions. Our website has resources and features that make it easy to get quality care. Our website can be accessed at AmbetterHealth.com/en/IL. 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 include 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. Selecting a *PCP*.
5. *Deductible* and *copayment* accumulators.
6. Our *formulary* or preferred drug list.
7. *Member* Rights and Responsibilities.
8. Notice of Privacy Practices.
9. Current events and news.

Quality Improvement

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

1. Conducting a thorough check on *physician*s 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 *member*s to get annual tests such as a physical examination, cervical cancer screening, breast cancer screening, and immunizations.
4. A Quality Improvement Committee which includes *network provider*s to help us develop and monitor our program activities.
5. Investigating any *member* concerns regarding care received.

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

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

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

Refer to the Internal Grievance, Appeals, and External Review Procedures section of this *contract* for information on your right to appeal an *adverse benefit determination*.

Regarding the independent review procedures, this includes the denial of a request for *prior authorization* for non-network services when the *member* requests health care services from a provider that does not participate in the provider *network* because the clinical expertise of the provider may be *medically necessary* for treatment of the *member*'s medical condition and that expertise is not available in the provider network.

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

Affordable Care Act (ACA) means the comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and *Affordable Care Act (ACA)* was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law. This is often times referred to as Health Care Reform.

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

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

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

Ambulatory surgical center means any facility with a medical staff of providers 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 provider 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 mean laws of the state in which your *contract* was issued and/or federal laws.

Applied behavior analysis (ABA) means the application of behavioral principles to everyday situations, intended to increase or decrease targeted behaviors. ABA has been used to

improve areas such as language, self-help, and play skills, as well as decrease behaviors such as aggression, self-stimulatory behaviors, and self-injury.

Attending physician means the *physician* responsible for the care of a patient and/or the *physician* supervising the care of patients by residents, and/or medical students.

Authorization or ***authorized*** means our decision to approve the medical necessity or the appropriateness of care for a *member* by the *member*'s *PCP* or provider.

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

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

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

Balance billing means a *non-network provider* billing you for the difference between the provider's charge for a service and the *eligible expense*. *Network provider*s may not *balance bill* you for *covered service expenses* beyond your applicable *cost sharing* amounts. If you are ever *balance billed* contact Member Services immediately at the number listed on the back of your *member* identification card.

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

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

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

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

Bereavement counseling means counseling of *member*s 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.

Breast tomosynthesis means a radiologic procedure that involves the acquisition of projection images over the stationary breast, to produce cross-sectional digital three-dimensional images of the breast.

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

Center of Excellence means a *hospital* that:

1. specializes in a specific type or types of *medically necessary* transplants or other services; and
2. is a *network provider* who meets quality of care criteria established by us and/or an entity designated by us and is cost-efficient.

The fact that a *hospital* is a *network provider* does not mean it is a *Center of Excellence*.

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

Civil union means to allow same sex and different sex couples to enter into a civil union with all the obligations, protections, and legal rights that Illinois provides to married heterosexual couples.

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

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

Complications of pregnancy means:

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

Continuing care patient means an individual who, with respect to a provider or facility, 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 and the applications.

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

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

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

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

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

1. Provided or incurred while the *member*'s coverage is in force under this *contract*;
2. Covered by a specific benefit provision of this *contract*; and

3. Not excluded anywhere in this *contract*.

Custodial care 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 an *illness* or bodily *injury*.

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

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

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

If you are a covered *member* in a family of two or more *member*s, 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 *member*s of your family are still responsible for their *deductible* until the family *deductible amount* is satisfied for the calendar year.

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

Dependent member means the primary *subscriber*'s lawful *spouse*, civil union 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 cancer clinical trial means a cancer clinical trial that meets all of the following criteria:

1. A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
2. The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
3. The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
4. The trial does one of the following:
    a. Tests how to administer a health care service, item, or drug for the treatment of cancer;
    b. Tests responses to a health care service, item, or drug for the treatment of cancer;
    c. Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
    d. Studies new uses of a health care service, item, or drug for the treatment of cancer.
5. The trial must meet the following criteria:
    a. The effectiveness of the treatment has not been determined relative to established therapies;
    b. The trial is under clinical investigation as part of an approved cancer research trial in Phase II, Phase III, or Phase IV of investigation;
    c. The trial is approved by the Food and Drug Administration; or
    d. The trial is approved and funded by one of the following entities:
        i. National Institutes of Health, the Centers for Disease Control and Prevention, the Agency of Healthcare Research and Quality;
        ii. The United States Department of Defense;
        iii. The United States Department of Veterans' Affairs;
        iv. The United States Department of Energy in the form of an investigational new drug application, or a cooperative group or center of any entity described.
    e. The patient's *primary care physician (PCP)*, if any, is involved in the coordination of care.

Eligible child means the child of a *member*, if that child is less than 26 years of age. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child;
3. A stepchild;
4. A child placed with you for adoption;

5. A child for whom legal guardianship has been awarded to you or your *spouse*. It is your responsibility to notify the entity with which you enrolled (either GetCovered Illinois or us) if your child ceases to be an *eligible child*. You must reimburse us for any benefits that we provide or pay for a child at a time when the child did not qualify as an *eligible child*;
6. A child who is in your custody, pursuant to an interim court order of adoption; or
7. A foster child placed in your custody, regardless of whether the child is residing with the *member*.

Coverage is extended for unmarried *eligible child* under the age of 30 if the *dependent member*:

1. is an Illinois resident;
2. served as a *member* of the active or reserve components of any of the branches of the Armed Forces of the United States; and
3. has received a release or discharge other than a dishonorable discharge.

To be eligible for coverage, the unmarried *eligible child* shall submit to Ambetter a form approved by the Illinois Department of Veterans' Affairs stating the date on which the unmarried *eligible child* was released from service.

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

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

1. For *network provider*s: When a *covered service* is received from a *network provider*, the *eligible expense* is the *contract*ed fee with that provider.
2. For *non-network provider*s, unless otherwise required by federal or Illinois law, the *eligible expense* is as follows:
    a. When *balance billing protections* apply to a *covered service* provided by 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 required by *applicable law*.
    b. For all other *covered services* provided by 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 condition means a medical condition or a *behavioral health* condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

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

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

Follow-up care is not considered emergency care. Benefits are provided for *emergency services* without *prior authorization*. Benefits for *emergency services* include facility costs and *physician* services and supplies and *prescription drug*s charged by that facility. If you are admitted to a *hospital* as a result of an *emergency condition*, you must notify us or verify that your *physician* has notified us of your admission within 48 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the *inpatient* setting is appropriate, and if appropriate, the number of days considered *medically necessary*. By contacting us, you may avoid financial responsibility for any *inpatient* care that is determined to be not *medically necessary* under your *contract*. If your provider does not *contract* with us, you may be financially responsible for any care we determine is not a *covered service* because it is not *medically necessary*. Care and treatment provided once you are *stabilize*d 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 *grievance* where any of the following applies:

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

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. Subject to FDA approval, and:
    a. It does not have FDA approval;
    b. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has FDA approval but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a FDA-approved drug is a use that is determined *medically necessary* 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
    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*.
3. *Experimental or investigational* according to the provider's research protocols.

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

Extended care facility 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.

Formulary means our list of covered drugs available on our website at AmbetterHealth.com/en/IL or by calling Member Services.

1. Generic drug is a drug that is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the FDA as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug. Generic drugs will be dispensed whenever available.
2. Brand drug is a *prescription drug* that has been patented and is only available through one manufacturer. Preferred brand drugs will be dispensed if there is not a generic. Brand drugs are also often preferred because they are safer or more successful in producing a desired or intended result.

3. Non-Preferred drug is a *prescription drug* covered under a higher *cost share*. This tier of drug contains both *formulary* brand name and generic drugs. These drugs require higher *copay* because other alternatives may be available in the lower tiers or there may be other generic equivalents available.
4. Specialty drugs are typically high-cost drugs, including but not limited to, the oral, topical, inhaled, inserted or implanted, and injected routes of administration. Included characteristics of specialty drugs are drugs that are used to treat and diagnose rare or complex diseases, require close clinical monitoring and management, frequently require special handling, and may have limited access or distribution. Specialty drugs are often also drugs that require special handling, or special or enhanced patient administration and oversight.

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

If no credible scientific evidence is available, then standards 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 service* 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 *medically necessary*.

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

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

Grievance Committee means individuals who have been appointed by us to respond to *grievances* that have been filed on *appeal* from our simplified *complaint* process established pursuant to the regulation. At least 50 percent of the individuals on this committee will be *member*s who are consumers.

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

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

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

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

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

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

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

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

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

Hospital means an institution that:

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

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

Iatrogenic infertility means impairment of fertility by *surgery*, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

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

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

Immunosuppressant drugs mean drugs that are used in immunosuppressive therapy to inhibit or prevent the activity of the immune system. "*Immunosuppressant drugs*" are used clinically to prevent the rejection of transplanted organs and tissues, including written prescriptions indicating no substitutions. "*Immunosuppressant drugs*" do not include drugs for the treatment of autoimmune diseases or diseases that are most likely of autoimmune origin.

Infertility means a disease, condition, or status characterized by:

1. a failure to establish a *pregnancy* or to carry a *pregnancy* to live birth after 12 months of regular, unprotected sexual intercourse if the woman is 35 years of age or younger, or after 6 months of regular, unprotected sexual intercourse if the woman is over 35 years of age; conceiving but having a miscarriage does not restart the 12-month or 6-month term for determining *infertility*;
2. a person's inability to reproduce either as a single individual or with a partner without medical intervention; or
3. a licensed *physician*'s findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

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

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

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

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

Intoxicated means that which is defined and determined by the laws of jurisdiction where the *loss* or cause of the *loss* was incurred.

Licensed mental health professional means a professional that holds a clinical license in a *behavioral health* discipline; and possesses the training or experience to complete the required evaluation and treatment of *behavioral health* disorders.

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

Low-dose mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than one rad per breast for two views of an average size breast (also includes digital mammography).

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

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

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

Medical practitioner or ***other practitioner*** include, but is not limited to, a *physician*, advanced practice nurse, licensed mental health professional, nurse anesthetist, *physician*'s assistant, physical therapist, midwife, *rehabilitation* licensed practitioner, or registered surgical assistant. The following are examples of providers that are NOT *medical practitioner*s, by definition of the *contract*: acupuncturist, rolfer, registered nurse, hypnotist, respiratory therapist, x-ray technician, emergency medical technician, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

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

Charges incurred for treatment not *medically necessary* are not *eligible expense*s.

***Medically necessary* medical supplies** mean medical supplies that are:

1. *Medically 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.

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

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 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, GetCovered Illinois (“Marketplace”) plans, most individual plans sold outside of the Marketplace, Medicare, Medicaid, Children Health Insurance Program (CHIP), TRICARE, COBRA and plans sold through the Small Business Health Insurance Program (SHOP) Marketplace.

Mobile integrated health care services mean *medically necessary* health services provided on-site by emergency medical services personnel. These services can be provided to *member*s who have received *hospital* emergency room services three or more times in a period of four consecutive months in the past 12 months or a *member* that has been identified by a health care provider as an individual for whom these services would likely prevent admission or readmission to or would allow discharge from a *hospital*, *behavioral health* facility, acute care facility, or nursing facility.

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 *member*s for an agreed upon fee. *Member*s 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* directly or indirectly with Ambetter of Illinois insured by Celtic Insurance Company to provide *covered services* to *member*s enrolled under this *contract*, including but not limited to,

hospitals, specialty *hospitals*, urgent care facilities, *physician*s, pharmacies, laboratories and other health professionals.

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 Medical Service 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*; or
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 that for services scheduled within 72 hours, the notice must be provided at least 3 hours before the services are furnished.
3. The *member* provides written consent to be treated by the *non-network provider* that includes the following:
    a. The *member's* acknowledgement that they have been provided written notice as described above and informed that payment of the *non-network provider*'s *billed amount* may not accrue toward the *member*'s *deductible* or *maximum out-of-pocket amount*;
    b. The *member's* statement that by signing the consent, they agree to be treated by the *non-network provider* and understand they may be *balance billed* and subject to *cost sharing* that applies to *non-network provider*s; 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 nonemergency medical transportation to an available *network provider* or facility located within a reasonable travel distance, taking into consideration the *member*'s medical condition.
2. The *member* (or the *member*'s *authorized representative*) is in a condition to provide *notice and consent* as determined by the *attending physician* or treating provider using appropriate medical judgment.
3. The *non-network provider* satisfies any additional requirements or prohibitions as may be imposed under *applicable law*.

Opioid antagonist means a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors.

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

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

Other practitioner as used in your *Schedule of Benefits* and related to mental health/*substance use disorder* services, means 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 mean 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. These facilities may include but are not limited to, a non-hospital site providing diagnostic and therapy services, *surgery*, or *rehabilitation*, or other *provider facility*. Professional charges only include services billed by a *physician* or other professional.

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

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

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

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

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

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

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

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

Primary care physician (PCP) means a provider who gives or directs health care services for you. *PCP*s include internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), *Physician* Assistants (PA), obstetrician gynecologist (ob-gyn), and pediatricians or any other practice allowed by 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* or provider group to the *member* prior to receiving services.

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

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

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

Qualified health plan* or *QHP means a health plan that has in effect a certification that it meets the standards issued or recognized by GetCovered Illinois through which such plan is offered.

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

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

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

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

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

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

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 cancellation or discontinuance of coverage that has a retroactive effect. *Rescission* does not include a cancellation or discontinuance or coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost 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*, *maximum out-of-pocket amount* and other limits that apply when you receive *covered services* and supplies.

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

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

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

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

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

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

Spouse means the person to whom you are lawfully married or, if you are a party to a civil union under the Illinois Religious Freedom Protection and Civil Union Act, the other party to such civil union.

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).

Standard fertility preservation services mean procedures based upon current evidence-based standard of care established by the American Society of Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

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

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

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

Surgery or surgical procedure means:

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

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.

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

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

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

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

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

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

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

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

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

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

DEPENDENT MEMBER COVERAGE

Dependent Member Eligibility

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

1. The date you became covered under this *contract*;
2. The date of marriage to add a *spouse*;
3. The date of an eligible newborns birth;
4. The date that an adopted child is placed with the *subscriber* for the purposes of adoption, when an *eligible child* is placed in the custody of you and your *spouse* pursuant to an interim court order of adoption vesting temporary care of the child to you or your *spouse*, regardless of whether a final order granting adoption is ultimately issued or the *subscriber* assumes total or partial financial support of the child.

Effective Date for Initial Dependent Members

Dependent members included in the initial enrollment application for this *contract* will be covered on your *effective date*. 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 *member* identification card.

Coverage for a Newborn Child

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

Additional premium will be required to continue coverage beyond the 31st day after the date of birth. Notice of the newborn must be given to us within 31 calendar days after the date of birth in order to have the coverage continue after the 31-day period and will require payment of the additional premium. If notice is not given within the 31 calendar days from birth, we will charge an additional premium from the date of birth. If notice is given by GetCovered Illinois 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 day after birth, unless we have received notice from the entity that you have enrolled with (either GetCovered Illinois or us).

Coverage for an Adopted Child

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

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

Additional premium will be required to continue coverage beyond the 31st day following placement of the child and we have received notification from GetCovered Illinois. Notice of the placement must be given to us within 31 calendar days after the placement in order to have the coverage continue after the 31-day period and will require payment of the additional premium. The required premium will be calculated from the date of placement for adoption. Coverage of the child will terminate on the 31st day following placement, unless we have received both:

1. notification of the addition of the child from GetCovered Illinois within 60 calendar days of the birth or placement and
2. any additional premium required for the addition of the child within 90 calendar days of the date of placement.

As used in this provision, "placement" means the assumption and retention by you or your *spouse* for total or partial support of the child in anticipation of the adoption of the child. Placement includes when an *eligible child* is placed in the custody of you or your *spouse* pursuant to an interim court order of adoption vesting temporary care of the child in you or your *spouse*, regardless of whether a final order granting adoption is ultimately issued.

Coverage for a Dependent Parent

Coverage is available to the parent or stepparent of the *member* if the parent or stepparent meets the definition of a qualifying relative under 26 U.S.C. 152(d) and lives or resides within the *contract's* service area.

Adding Other Dependent Members

If you are enrolled in an off-exchange *contract* and apply in writing, or directly at enroll.ambetterhealth.com, to add 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 *member* identification cards for the added *dependent member*.

ELIGIBILITY AND ENROLLMENT

For All Members

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

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

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 GetCovered Illinois at www.getcovered.illinois.gov or 1-866-311-1119. If you enrolled through Ambetter, contact Member Services.

Prior Coverage

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

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

For Dependent Members

A *dependent member* will cease to be a *member* at the end of the premium period in which he or she ceases to be your *dependent member* due to divorce or if a child ceases to be an *eligible child*.

A *dependent member* will cease to be a *member* at the end of the premium period in which he or she ceases to be your dependent *member* due to divorce or if a child ceases to be an *eligible child*. For eligible children, the coverage will terminate the thirty-first day of December the year the dependent turns 26 years of age. All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*.

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 you for support.

Dependent Medical Leave of Absence

Coverage will continue for a *dependent member* college student who takes a medical leave of absence or reduces his or her course load to part-time status because of a catastrophic *illness* or *injury*. Continuation of coverage for such a *dependent member* college student will automatically terminate 12 months after notice of the *illness* or *injury* or until coverage would have otherwise lapsed pursuant to the terms and conditions of this *contract*, whichever comes first, provided the need for part-time status or medical leave of absence is supported by a clinical certification of need from a *physician* licensed to practice medicine in all its branches.

Open Enrollment

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

GetCovered Illinois may provide a coverage *effective date* for a *qualified individual* earlier than specified in the paragraphs above, provided that either:

1. The *qualified individual* has not been determined eligible for advanced payments of the premium tax credit or *cost sharing reductions*; or
2. The *qualified individual* pays the entire premium for the first partial month of coverage as well as all *cost sharing*, thereby waiving the benefit of advanced payments of the premium tax credit and *cost sharing* reduction payments until the first of the next month. We will send written annual open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

Special Enrollment Periods

In general, a *qualified individual* has 60 calendar days to report certain life changes, known as "qualifying events" to GetCovered Illinois or by using Ambetter's Enhanced Direct Enrollment tool, and could be granted a 60-calendar day special enrollment period as a result. *Qualified individual*s may be granted a special enrollment period where they may enroll in or change to a different Marketplace plan during the current plan year if they have a qualifying event.

Qualifying events include:

1. A *qualified individual* or dependent experiences a *loss* of minimum essential coverage, non-calendar year group or individual health insurance coverage, *pregnancy*-related coverage, access to health care services through coverage provided to a pregnant *member*'s unborn child, or medically needed coverage;
2. A *qualified individual* gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order. 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 calendar days during the 60 calendar days preceding the date of marriage;
3. A *qualified individual* or dependent, who was not previously a citizen, national, or lawfully present individual gains such status; or who is no longer incarcerated or whose incarceration is pending the disposition of charges;
4. A *qualified individual*'s enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or its instrumentalities as evaluated and are determined by GetCovered Illinois;
5. A *member* or dependent adequately demonstrates to GetCovered Illinois that the plan in which he or she is enrolled substantially violated a material provision of its *contract* in relation to the *member*;
6. A *qualified individual*, *member*, or dependent, adequately demonstrates to GetCovered Illinois that a material error related to plan benefits, *service area*, or premium influenced the *qualified individual*'s or *member*'s decision to purchase the *QHP*;
7. A *member* or dependent enrolled in the same plan is determined newly eligible or newly ineligible for *advance premium tax credits* or has a change in eligibility for *cost sharing reductions*;
8. A *qualified individual* or dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for *advanced premium tax credits* based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-2(c)(3);
9. A *qualified individual*, *member*, or dependent gains access to new *QHP*s as a result of a permanent move, and had minimum essential coverage as described in 26 CFR 1.5000A–1(b) for one or more calendar days during the 60 calendar days preceding the date of the permanent move;

10. A *qualified individual* or dependent who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a plan or change from one plan to another one time per month;
11. A *qualified individual* or *member* demonstrates to GetCovered Illinois, in accordance with guidelines issued by the U.S. Department of Health and Human Services (HHS), that the individual meets other exceptional circumstances as GetCovered Illinois may provide;
12. A *qualified individual*, *member*, or dependent is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B–2, and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
13. A *qualified individual* or dependent is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 calendar days after the qualifying event; or applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;
14. A *qualified individual* newly gains access to an employer sponsored Individual Coverage Health Reimbursement Arrangement (ICHRA) (as defined in 45 CFR 146.123(b)) or a Qualified Small Employer Health Reimbursement Arrangement (QSHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code);
15. At the option of GetCovered Illinois, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a plan through GetCovered Illinois following termination of enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence; or
16. A *qualified individual* or dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions or government subsidies completely cease.
17. A *qualified individual* or *member*, or their *dependent member*, who is eligible for advance payments of the premium tax credit, and whose household income is projected to be at or below 150 percent of the federal poverty level.

To determine if you are eligible and apply for a special enrollment period, please visit www.getcovered.illinois.gov and search for "special enrollment period." GetCovered Illinois is responsible for all health care eligibility and enrollment decisions for *member*s who enrolled via the Marketplace.

If you are currently enrolled in Ambetter of Illinois insured by Celtic Insurance Company, please contact Member Services with any questions related to your health insurance coverage.

Coverage Effective Dates for Special Enrollment Periods

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

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

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

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

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

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

PREMIUMS

Premium Payment

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

Grace Period

When a *member* is receiving a premium subsidy:

After the first premium is paid, a grace period of three months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first 31 calendar days of the grace period, if *advanced premium tax credits* are received.

We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first 31 calendar days of the grace period and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. We will notify HHS of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the second and third month of the grace period. We will continue to collect *advanced premium tax credits* on behalf of the *member* from the Department of the Treasury and will return the *advanced premium tax credits* on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above.

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

Premium payments are due in advance on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 60-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* of the non-payment of premiums, as well as providers of the possibility of denied claims when the *member* is in the grace period.

Third-Party Payment of Premiums or Cost Sharing

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

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

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

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

Misstatement of Age

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

Change or Misstatement of Residence

If you change your *residence*, you must notify GetCovered Illinois 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.

Misstatement of Tobacco or Nicotine Use

The answer to the tobacco or nicotine question on the enrollment application is material to our correct underwriting. If a *member*'s use of tobacco or nicotine has been misstated on the *member*'s application for coverage under this *contract*, we have the right to 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 the *Schedule of Benefits* and the Major Medical Expense Benefits sections of this *contract*. All benefits we pay will be subject to all conditions, limitations, and *cost sharing* features of the *contract*. *Cost sharing* means that you participate or share in the cost of your health care services by paying *deductible amounts*, *copayments* and *coinsurance* for some *covered services*. For example, you may need to pay a provider a *deductible*, *copayment* or *coinsurance amount* when you visit your *physician* or are admitted into the *hospital*. The *copayment* or *coinsurance* required for each type of service as well as your *deductible* is listed in your *Schedule of Benefits*.

When you, or a covered *dependent member*, receive health care services from a provider, there may be multiple claims for that episode of care. An episode of care means the services provided by a health care facility or provider to treat a condition or an *illness*. Each claim that we receive for services covered under this *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*.

Copayments

A *copayment* is typically a fixed dollar amount due at the time of service. *Member*s may be required to pay *copayments* to a provider each time services are performed that require a *copayment*. *Copayments*, as shown in the *Schedule of Benefits*, are due at the time of service. Payment of a *copayment* does not exclude the possibility of a provider billing you for any non-*covered 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 a provider a *coinsurance* in addition to any applicable *deductible amount(s)* due for a *covered service* or supply. Payment of a *coinsurance amount* does not exclude the possibility of a provider billing you for any non-covered services. *Coinsurance amounts* do not apply toward the *deductible* but do apply toward your *maximum out-of-pocket amount*. When the annual *maximum out-of-pocket amount* has been met, additional *covered services* will be provided at 100 percent.

Deductible

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

Maximum Out-of-Pocket Amount

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

After the *maximum out-of-pocket amount* is met for an individual, Ambetter 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 amount*s are shown in the *Schedule of Benefits*.

For family coverage, the family *maximum out-of-pocket amount* can be met with the combination of any one or more covered persons' *eligible expenses*. A covered person'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 *member*s, you will satisfy your maximum out-of-pocket when:

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

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

The amount provided or payable will be subject to:

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

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

Emergent Services Only: If you receive emergent services from a *non-network provider*, you are responsible for an amount equal to your responsibility for similar services provided by a *network provider*. If you believe you have been billed in error, please contact Member Services.

Non-Network Liability and Balance Billing

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

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

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

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

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

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

Your network *PCP* will be responsible for coordinating all covered health services with other *network provider*s.

Changing Your Primary Care Physician (PCP)

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

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

Should you need care outside of your *PCP*'s office hours, you should call your *PCP*'s office for information on receiving after hours care in your area. If you are experiencing an *emergency condition*, call 911 or for a *behavioral health emergency condition*, call 988 or go to the nearest emergency room.

Provider Contracts: Notice of Nonrenewal or Termination

We will provide at least 60 calendar days' notice of nonrenewal or termination of a health care provider to the health care provider and to the *member*s served by the health care provider. The notice shall include a name and address to which a *member* or health care provider may direct comments and concerns regarding the nonrenewal or termination. Immediate written notice may be provided without 60 calendar days' notice when a health care provider's license has been disciplined by a state licensing board.

Non-Emergency Services

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

Emergency Services Outside of Service Area

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

If you are temporarily out of the *service area* and experience an *emergency condition*, call 911 or for a *behavioral health emergency condition*, call 988 or go the nearest emergency room. Please notify us of your emergency within one business day or as soon as reasonably possible. You do not need *prior authorization* for *emergency services*.

Continuity of Care

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

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

Hospital Based Providers

When receiving care at a network *hospital* it is possible that some *hospital*-based providers may not be *network provider*s. 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*.

Protection from Balance Billing

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

New Technology

Health technology is always changing. If we think a new medical advancement can benefit our *member*s, 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 *member*s. The Clinical Policy Committee (CPC) reviews requests for coverage and decides whether we should change any of our benefits to include the new technology.

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

Preferred Partnership

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

Network Availability

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

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*.

MEDICAL SERVICE BENEFITS

The plan provides coverage for health care services for a *member* or covered *dependent member*. Some services require *prior authorization*. *Copayment*, *deductibles*, and *coinsurance amounts* must be paid to your *network provider* at the time you receive services. All *covered services* are subject to conditions, exclusions, limitations, terms and provisions of this *contract*. *Covered services* must be *medically necessary* and not *experimental or investigational*.

Essential health benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, *emergency services*, hospitalization, maternity and newborn care, mental health and *substance use disorder* services, including *behavioral health* treatment, *prescription drug*s, 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 under 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.

Benefit Limitations

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

Acquired Brain Injury Services

Benefits for *eligible expenses* incurred for *medically necessary* treatment of an *acquired brain injury* will be determined on the same basis as treatment for any other physical condition, if such services are necessary as a result of and related to an *acquired brain injury* 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*, post-acute transition services and community reintegration services, including outpatient day treatment services, or any other post-acute treatment services are covered.

Treatment for an *acquired brain injury* may be provided at a *hospital*, an acute or post-acute *rehabilitation hospital*, a *skilled nursing facility* or any other facility at which *covered services* are provided.

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 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.

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

Ambulance Services

Air Ambulance Service Benefits

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

1. In cases where the *member* is experiencing an *emergency condition*, to the nearest *hospital* that can provide *emergency services* appropriate to treat the *member*'s *emergency condition*.
2. To the nearest neonatal special care unit for newborn infants for treatment of illnesses, injuries, congenital birth defects, or complications of premature birth that require that level of care.
3. Transportation between *hospitals* or between a *hospital* and a more appropriate level of care when *authorized* by Ambetter of Illinois insured by Celtic Insurance Company.
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 transportation requires *prior authorization*. *Prior authorization* is not required for air ambulance transportation when the *member* is experiencing an *emergency condition*. Please note: You should not be *balance billed* for covered air ambulance services.

Limitations: Benefits for air ambulance services are limited to:

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

Exclusions:
No benefits will be paid for:

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

Ambulance Service Benefits (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 more appropriate level of care when *authorized* by Ambetter of Illinois insured by Celtic Insurance Company.
4. When ordered by an employer, school, fire or public safety official and the *member* is not in a position to refuse; or
5. When a *member* is required by us to move from a *non-network provider* to a *network provider*.

Prior authorization is not required for emergency ambulance transportation. **Note**: Non-emergency ambulance transportation requires *prior authorization*. You should not be *balance billed* for services from a non-network ambulance provider, beyond your *cost share*, for ground and water ambulance services.

Exclusions:
No benefits will be paid for:

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

4. Non-emergency transportation.

Autism Spectrum Disorder 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. habilitation services for individuals with a diagnosis of autism spectrum disorder;
5. speech therapy;
6. occupational therapy;
7. physical therapy;
8. psychiatric care such as counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor, or clinical social worker; and
9. medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

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

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.

Chiropractic and Osteopathic Services

We cover charges for chiropractic and osteopathic services on an outpatient basis. See your *Schedule of Benefits* for benefit levels or additional limits.

Clinical Trial Coverage

Clinical trial coverage includes routine patient care costs incurred as the result of an approved phase I, II, III or phase IV clinical trial and the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition. Coverage will include routine patient care costs incurred for (1) drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, (2) reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial and (3) all items and services that are otherwise generally available to a *qualified individual* that are provided in the clinical trial except:

1. The investigational item or service itself:
2. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
3. Items and services customarily provided by the research sponsors free of charge for any *member* in the trial.

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

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

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

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

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

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 Ambetter upon request.

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

Diabetic Care

Benefits are available for *medically necessary* service items and diabetic supplies used in the treatment of persons with gestational, type I or type II diabetes where such supplies are prescribed by a provider for diabetes as adopted and published by the Diabetes Initiative of Illinois. *Covered services* include, but are not limited to:

1. Telehealth services;
2. Examinations including podiatric examinations;
3. Routine foot care such as trimming of nails and corns;
4. Laboratory and radiological diagnostic testing;
5. Self-management equipment, and supplies such as urine and/or ketone strips;
6. Continuous glucose monitors;
7. Blood glucose monitor supplies (glucose strips) for the device, and syringes or needles;
8. Orthotics and diabetic shoes;
9. Urinary protein/microalbumin and lipid profiles;
10. Educational health and nutritional counseling for self-management;
11. Eye examinations;
12. Prescription medication; and
13. Retinopathy examination screenings as *medically necessary*.

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

Dialysis Services

Medically necessary acute and chronic dialysis services are *covered services* unless other coverage is primary, such as Medicare, for dialysis. Provided you meet all the criteria, there are two types of treatment options. You may receive hemodialysis in a network 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 Equipment and Supplies

Disposable medical supplies, which have a primary medical purpose, are covered and are subject to reasonable quantity limits as determined *medically necessary*. 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 amount*, *copayment amount*, and *coinsurance amount*.

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

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

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

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

1. The equipment, supply or appliance is worn out or no longer functions.

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

Benefits for repairs and replacement do not include the following:

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

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

Durable Medical Equipment

The rental (or, at our option, the purchase) of *durable medical equipment* prescribed by a *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. The plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are *covered services*. Payment for related supplies is a *covered service* only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the *member*; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered services may include, but are not limited to:

1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for IV fluids and medicine.
5. Glucometer.
6. Tracheotomy tube.
7. Cardiac, cardiopulmonary, neonatal and sleep apnea monitors.
8. Augmentive communication devices are covered when we approve based on the *member*'s condition.
9. Rental of one Continuous Passive Motion (CPM) machine per *member* following a covered joint surgery.
10. Wheelchairs
11. Hospital beds

Durable medical equipment and supplies are subject to *prior authorization* as outlined in this *contract*. Please 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 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 device*s 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 device*s 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. *Prosthetic* or custom orthotic device determined by the *member's* provider to be the most appropriate model that is *medically necessary* for the *member* to perform physical activities, as applicable, such as running, biking, swimming, and lifting weights, and to maximize the *member's* whole-body health and strengthen the lower and upper limb function.
3. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
4. 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 device*s, if any, do not apply.
5. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
6. 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.
7. Cochlear implants, bone anchored hearing aids, and related fittings.
8. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
9. Restoration prosthesis (composite facial prosthesis).
10. Coverage for osseointegrated auditory implants

11. One pair of foot orthotics per year per covered person.
12. Wigs or scalp prosthetics (not to exceed one per benefit period), when purchased through a *network provider*.

Exclusions:

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

1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. 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 device*s 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 device*s may be replaced once per year per *member* when *medically necessary* in the *member*'s situation. However, additional replacements will be allowed for *member*s under age 18 due to rapid growth, or for any *member* when an appliance is damaged and cannot be repaired.

Exclusions:

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

1. Foot support devices, such as arch supports, unless they are an integral part of a leg brace.

2. Garter belts and other supplies not specially made and fitted (except as specified under the Medical Supplies provision).

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, seven days a week.

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

Covered services may include *mobile integrated health care services*. This includes, but are not limited to, the following:

1. Health assessment;
2. Chronic disease monitoring and education;
3. Medication compliance;
4. Immunizations and vaccinations;
5. Laboratory specimen collection;
6. *Hospital* discharge follow-up care; and
7. Minor medical procedures as approved by the applicable EMS medical director.

Note: *Mobile integrated health care services* does not include non-emergency ambulance transportation.

Family Planning and Contraception

Family planning and contraceptive benefits are covered under preventive care, without *cost sharing*, when provided by a *network provider* and the care is legal under *applicable law*. These benefits include the following for adolescent and adult women, in accordance with the most recent guidelines supported by the Health Resources and Service 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.
5. Coverage is available for at-home, urine-based *pregnancy* tests that is prescribed by a provider, regardless of whether the tests are otherwise available over-the-counter. Coverage is limited to two at-home tests every 30 days.

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

Fertility Preservation Services

Coverage for *medically necessary* expenses for standard fertility preservation services when a necessary medical treatment may directly or indirectly cause *iatrogenic infertility* to a *member*. *Prior authorization* may be required.

Habilitation Expense Benefits

Covered service expenses provided for *medically necessary habilitation services* shall include:

1. Outpatient physical *rehabilitation* services including speech and language therapy and/or occupational therapy, performed by a licensed therapist.

2. Clinical therapeutic intervention defined as therapies supported by empirical evidence, which include but are not limited to *applied behavior analysis*, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the services in accordance with a treatment plan.
3. Mental/*behavioral health outpatient services* performed by a licensed psychologist, psychiatrist, or *physician* to provide consultation, assessment, development and oversight of treatment plans.

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

Habilitative Services for Children

Covered services provided for habilitative services for children through age 19 with a congenital, genetic, or early acquired disorder so long as all of the following conditions are met:

1. A *physician* licensed to practice medicine in all its branches has diagnosed the child's congenital, genetic, or early acquired disorder.
2. The treatment administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, licensed *physician*, licensed nurse, licensed optometrist, licensed nutritionist, licensed social worker, or licensed psychologist.

The initial or continued treatment must be *medically necessary* and therapeutic and not *experimental or investigational*.

This *contract* will not deny *medically necessary* habilitative services for children solely because of the location wherein the clinically appropriate services are provided.

Home Health Care

Covered service expenses 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. Skilled services of a registered nurse or licensed practical nurse rendered on an outpatient basis.
3. Services of a private duty registered nurse rendered on an outpatient basis.
4. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care*. Please refer to your *Schedule of Benefits* for any limits associated with this benefit.
5. Intravenous medication and pain medication to the extent they would have been *covered service expenses* during an *inpatient* hospital stay.

6. Hemodialysis, and for the processing and administration of blood or blood components.
7. *Medically necessary medical supplies*.
8. Hospital laboratory services to the extent they would have been *covered service expenses* during an *inpatient* hospital stay.
9. Rental or purchase of *medically necessary durable medical equipment* at the discretion of the plan. At our option, we may *authorize* the purchase of the equipment from a *network provider* in lieu of its rental if the rental price is projected to exceed the equipment purchase price.

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

Limitations:

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

Exclusion:

No benefits will be payable for charges related to *respite care*, *custodial care*, or educational care.

Hospice Care Service Expense Benefits

This provision 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 *member*s from the duties of caring for a *member* who is undergoing under *hospice* care. Respite days that are applied toward the *member*'s *cost share* obligations are considered benefits provided and shall apply against any maximum benefit limit for these services. See your *Schedule of Benefits* for coverage limits.

The list of *covered services* is expanded to include:

1. Room and board in a *hospice* while the *member* is an *inpatient*.
2. Coordinated home care.
3. Medical supplies and dressings.
4. Medications.
5. Skilled and non-skilled nursing services.
6. Physical and occupational therapy.
7. Speech-language therapy.
8. *Physician* visits.
9. The rental of medical equipment while the *terminally ill* covered person is in a *hospice* care program to the extent that these items would have been covered under the *contract* if the *member* had been confined in a hospital.

10. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
11. Community-based pediatric palliative care and *hospice* care to any qualifying child with a serious *illness* by a trained interdisciplinary team. *Covered services* include community-based pediatric palliative care and *hospice* care while continuing to pursue curative treatment and disease-directed therapies for the qualifying *illness*.
12. Counseling the *member* regarding his or her terminal *illness*.
13. *Terminal illness counseling* of the *member*'s *immediate family*.
14. *Bereavement counseling*.
15. *Respite care* services.

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.

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

Hospital Benefits

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

1. Daily room and board and nursing service, 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 for *surgery*.
4. Outpatient use of an operating, treatment, or recovery room for *surgery*.
5. Services and supplies, including drugs and medicines, which are routinely provided by the hospital to persons for use only while they are *inpatient*s.
6. Emergency treatment of an *injury* or *illness*, even if confinement is not required. See your *Schedule of Benefits* for limitations.
7. A private *hospital* room when needed for isolation.

If you receive emergent services from a *non-network provider*, you are responsible for an amount equal to your responsibility for similar services provided by a *network provider*. If you believe you have been billed in error, please contact Member Services.

Infertility Expense Benefits

Infertility coverage for the diagnosis and treatment of *infertility* including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, oocyte retrieval, intracytoplasmic sperm injection, and surgical sperm extraction procedures is covered to the extent the treatment is legal under *applicable law*.

Coverage for procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer shall be required only if:

1. The *member* has been unable to attain or sustain a successful *pregnancy* through reasonable, less costly medically appropriate *infertility* treatments for which coverage is available under the *contract.*
2. The *member* has not undergone four completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals will be covered.
3. The procedures are performed at medical facilities that conform to the American College of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

Coverage for the diagnosis and treatment of infertility shall be required only if the procedures are:

1. Considered medically appropriate by the *member's* physician based on clinical guidelines or standards developed by the American Society for Reproductive Medicine, the American College of Obstetrics and Gynecology or the Society for Assisted Reproductive Technology
2. Performed at medical facilities or clinics that are members in good standing of the Society for Assisted Reproductive Technology

Coverage includes *medically necessary* procedures to screen or diagnose a fertilized egg before implantation including, but not limited to, preimplantation genetic testing for:

1. Aneuploidy
2. Chromosome structural rearrangements
3. Monogenic or single gene disorders

Long Term Acute Care Hospital

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.

Common conditions/services that may be considered *medically necessary* for LTACH level of care included, but 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, and orthopedic *surgery*
5. Mechanical ventilator support:
    a. Failed weaning attempts at an acute care facility
    b. Patient has received mechanical ventilation for 21 consecutive days for six hours or more/per day
    c. Ventilator management required at least every four hours as well as appropriate diagnostic services and assessments
    d. Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions
    e. Patient is hemodynamically stable and not dependent on vasopressors
    f. Respiratory status is stable with maximum PEEP requirement 10 cm H2O, and FiO2 60 percent or less with O2 saturation at least 90 percent
    g. Common conditions include complications of acute lung *injury*, disorders of the central nervous and neuromuscular systems, and cardiovascular, respiratory, and pleural/chest wall disorders
    h. Patient continues to meet the criteria above and does not meet the criteria to be transitioned to alternate level of care.

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

Lymphedema Benefit

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

Maternity Care

An inpatient stay is covered for mother and newborn for a minimum of 48 hours following a vaginal delivery and 96 hours following a delivery by cesarean section. We do not require that a 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 the health plan.

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

1. Outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, and childbirth classes. This includes:
    a. Access to clinically appropriate care management programs for *members* experiencing a high-risk pregnancy.
    b. For *medically necessary* inpatient and outpatient services for the treatment of a *behavioral health* condition related to pregnancy or postpartum complications.
2. Physician home visits and office services.
3. Pasteurized donated human breast milk, which may include human milk fortifiers, if indicated by a prescribing licensed medical practitioner and other conditions of *prior authorization* are met.
4. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
5. *Complications of pregnancy*.
6. Hospital stays for other *medically necessary* reasons associated with maternity care.
7. Services related to termination of pregnancy, including medication abortion care, in accordance with *applicable law*. **Note**: Abortion care is covered at no *cost-share* to the *member*. In the event the *member* has an HSA-eligible plan, *cost share* is not waived until the *deductible* is met. *Prior authorization* is not required for these services.
8. For medical services or supplies for maternity deliveries at home, required for medical professional or *medically necessary* treatment.

9. Coverage for services for pregnancy, postpartum, and newborn care when rendered by a perinatal doula, midwives within the scope of that license or certification, or lactation consultants. *Covered services* would be provided without *cost sharing* to the *member*. Pursuant to federal regulation, the no *cost share* does not apply to *members* enrolled in an HSA-eligible plan. Please review your *Schedule of Benefits* to determine if your plan is HSA-eligible. *Covered services* include:
    a. Home births;
    b. Home visits by a perinatal doula;
    c. Support during labor, abortion, or miscarriage;
    d. *Medically necessary* equipment and supplies for a home birth;
    e. Breast pumps and supplies as recommended by the lactation consultant; and
    f. Coverage for postpartum services shall apply for at least one year after the end of the pregnancy.

Note: This provision does not amend the *contract* to restrict any terms, limits, or conditions that may otherwise apply to *covered services* 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 General Non-Covered Services and Exclusions section as limitations may exist.

Duty to Cooperate: We do not cover services or supplies related to a *member's* pregnancy when a *member* is acting as a *surrogate* and has entered into a *surrogacy arrangement*. For more information on excluded services, please see the General Non-Covered Services and Exclusions section. *Members* who are a *surrogate* at the time of enrollment or *members* who agree to a *surrogacy arrangement* during the plan year must, within 30 calendar days of enrollment or agreement to participate in a *surrogacy arrangement*, send us written notice of the *surrogacy arrangement* to:

Ambetter of Illinois
Member Services Department
200 East Randolph St.
Chicago, IL 60601

In the event that a *member* fails to comply with this provision, we reserve our right to enforce this provision on the basis of fraud, misrepresentation or false information, up to and including recoupment of all benefits that we paid on behalf of the *surrogate* during the time that the *surrogate* was insured under our *contract*, plus interest, attorneys' fees, costs and all other remedies available to us.

Newborn Charges

Medically necessary services, including *hospital* services, are provided for a covered newborn child at moment of birth. Each type of *covered service* incurred by the newborn child will be subject to his/her own *cost sharing* (*copayment, coinsurance percentage, deductible and maximum out-of-pocket amount*), as listed in the *Schedule of Benefits.*

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 authorization*s and *cost sharing* requirements and include, but are not limited to:

1. For *surgery* in a *physician*'s office, an *inpatient* facility, outpatient facility, or a surgical facility, including services and supplies;
2. For pre-surgical and post-surgical procedural 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.
    b. The tests must be for the same bodily *injury* or *illness* causing the *member* to be *hospital* confined or to have the outpatient *surgery* or procedure.
    c. Bone density studies;
    d. Clinical laboratory tests;
    e. Gastrointestinal laboratory procedures;
    f. Pulmonary function tests;
    g. Genetic testing;
    h. 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;
    i. For *medically necessary* home saliva cancer screening tests to detect early-stage cancer every 24 months if the *member*:
        i. is asymptomatic and at high risk for the disease being tested for; or
        ii. demonstrates symptoms of the disease being tested for a physical exam.
3. For medical services in an office or facility that is provided by a licensed *medical practitioner* or *specialist physician*, including consultations, and *surgery* related services;
4. For chemotherapy (including oral chemotherapy), inhalation therapy, infusion therapy, radiation therapy, and proton beam therapy or treatment in a *hospital*, or office setting;

5. For *durable medical equipment*, *prosthetic device*s, *orthotic device*s, or other necessary medical supplies following a medical or surgical procedure such as crutches, orthopedic splints, braces or casts. Please see the Durable Medical Equipment, Medical and Surgical Supplies, Orthotic devices, and Prosthetics provision of this *contract*;
6. For hemodialysis, and the charges by a *hospital* or facility for the processing and administration of genetic testing, blood or blood components, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for you;
7. For the cost and administration of anesthesia, oxygen, drugs, medications, and biologicals;
8. For *medically necessary* reconstructive or cosmetic *surgery* including, but not limited to:
    a. reconstructive breast *surgery* charges as a result of a partial or total mastectomy. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic device*s necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedema.
    b. *reconstructive surgery* for craniofacial abnormalities.
9. For *medically necessary* breast reduction *surgery*;
10. For *medically necessary* dental *surgery* due to:
    a. An accidental *injury* Which results in damage to natural teeth. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
    b. *Surgery* to correct a functional defect which results from a congenital and/or acquired disease or anomaly.
    c. Cleft lip and cleft palate for an eligible *member*. *Covered services* include medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the treating *physician* or surgeon and such *physician* or surgeon certifies that such services are *medically necessary* and consequent to treatment of the cleft lip or cleft palate.
    d. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* charges for dental care, rendered by a dentist, provided to the following *member*s:
        i. A *member* whose treating *medical practitioner* in consultation with the dentist, determines the *member* has a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or
        ii. A *member* who has one or more medical conditions that would create significant or undue medical risk for the *member* during delivery of any dental treatment or *surgery* if not rendered in a *hospital* or *ambulatory surgical center*.
        iii. Necessary dental treatment is that which, if left untreated, is likely to result in a medical condition. Use of general anesthesia in a *hospital* or *ambulatory surgical center* is subject to *prior authorization*. Please call Member Services to confirm your benefits for the use of general anesthesia in a *hospital* or *ambulatory surgical center*.

11. For *infertility* counseling and planning services, when provided by a *network provider* and testing to diagnose *infertility*, if the services are legal under *applicable law*;
12. 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;
13. For *medically necessary* pain medication and pain therapy related to the treatment of breast cancer;
14. For comprehensive cancer testing, including but not limited to:
    a. Targeted cancer gene panels;
    b. Whole-exome genome testing;
    c. Whole-genome sequencing;
    d. RNA sequencing; and
    e. Tumor mutation burden.
15. Breast examinations as follows:
    a. *Covered services* for a *member* will include mammography screenings that align with USPSTF A and B rated guidelines, as well as *applicable laws*. This coverage encompasses *medically necessary* preventive and diagnostic mammograms, digital breast tomosynthesis, magnetic resonance imaging (MRI), ultrasounds, and pathology evaluations. Coverage is available to all *members*, regardless of age, when these services are prescribed by a licensed healthcare provider within their professional scope. For further details on this benefit, please refer to the Preventive Care Guide.
16. Coverage includes services provided by a *physician*, an advanced practice nurse who has a collaborative agreement with a collaborating *physician* that authorizes breast examinations or a *physician* assistant who has been delegated authority to provide breast examinations. Services are covered without *cost sharing* when services are rendered by a *network provider*;
17. Pancreatic cancer screening;
18. For routine patient care for *member* enrolled in an *eligible cancer clinical trial* that is deemed an *experimental or investigational* treatment if the services provided are otherwise considered *covered services* under the *contract*. See Clinical Trial Coverage provision of this *contract*.
19. 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

20. For X-rays, Magnetic Resonance Imaging (MRI), Computer Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT), and other diagnostic services. See Radiology, Imaging and Other Diagnostic Testing provision of this *contract*;
21. For *medically necessary telehealth services* subject to the same clinical and *utilization review* criteria, plan requirements and limitations as the same health care services when delivered to a *member* in-person. *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. Pursuant to federal regulation, the $0 *cost share* does not apply to *member*s enrolled in an HSA-eligible plan. Please review your *Schedule of Benefits* to determine if your plan HSA-eligible;
22. For *surgery* or services related to cochlear implants and bone anchored hearing aids;
23. For *medically necessary* services for complications arising from medical and surgical conditions;
24. For bariatric *surgery*;
25. For respiratory, pulmonary, cardiac, physical, occupational, and speech therapy services. Please see Rehabilitation and Skilled Nursing Facility Expense Benefits provisions of this *contract*.
26. For maternity care services, including but not limited to, prenatal, postnatal, diagnostic testing, at-home pregnancy tests, laboratory services, and *hospital* services;
27. For *medically necessary* examination, testing, and antibiotic therapy for tick-borne disease;
28. 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;
29. For *medically necessary* footcare treatment that may require *surgery*; *prior authorization* may be required;
30. 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*;
31. For *medically necessary* biofeedback services;
32. For services associated with human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation or transplant procedure;
33. Male sterilization services are covered at no cost when services are rendered by a *network provider*;
34. For *medically necessary chiropractic care* or manipulative therapy treatment on an outpatient basis only. See your *Schedule of Benefits* for benefit levels or additional limits. *Covered services* are subject to all other terms and conditions of the *contract*, including the *deductible amount* and *cost sharing* provisions;

35. 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 examinations, and pulse oximetry;
36. For coverage of a vaccine for shingles that is approved for marketing by the federal Food and Drug Administration if the vaccine is ordered by a physician licensed to practice medicine in all its branches and the *member* is 60 years of age or older.
37. For *medically necessary* routine hearing exams and hearing aids. Coverage for one hearing instrument for each ear and related services is provided for *members*, once every 36 months
38. For *medically necessary* allergy testing, and treatment including allergy injections and serum;
39. Following a recommendation for elective *surgery*. Coverage will be provided at 100 percent of the *eligible expense* for one consultation and related diagnostic service by a *physician*. If requested, benefits will be provided for an additional consultation when the need for *surgery*, in your opinion, is not resolved by the first consultation;
40. Coverage for routine physical examinations for expenses incurred in the examination and testing of a victim of a criminal sexual assault or abuse from a *network provider* or a *non-network provider*. No *cost sharing* will apply;
41. Coverage for outpatient end stage renal disease treatment including both outpatient and *inpatient* settings based on medical necessity;
42. Coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome, including, but not limited to, the use of intravenous immunoglobulin therapy;
43. For *medically necessary* treatment of immune gamma globulin therapy for *members* diagnosed with a primary immunodeficiency;
44. Coverage to treat or eliminate port-wine stains (nevus flammeus) approved by the U.S. Food and Drug Administration in children aged 18 years and younger that are intended to prevent functional impairment related to vision function, oral function, inflammation, bleeding, infection, and other medical complications associated with port-wine stains. Treatment includes, but is not limited to:
    a. early intervention treatment;
    b. topical, intralesional, or systemic medical therapy; and
    c. *surgery* and laser treatments.
45. For *medically necessary* A1C testing to diagnose and monitor blood sugar levels for prediabetes, type I and type II diabetes;
46. For *medically necessary* vitamin D testing when recommended from a *network provider* and in accordance with vitamin D deficiency risk factors identified by the United States Centers for Disease Control and Prevention (CDC);

47. For *medically necessary* hormonal and non-hormonal therapy to treat menopause. *Covered services* would be provided without *cost sharing* to the *member*. Pursuant to federal regulation, the no *cost share* does not apply to *member*s enrolled in an HSA-eligible plan. Please review your *Schedule of Benefits* to determine if your plan is HSA-eligible;
48. For a colonoscopy that is determined *medically necessary*, and a colonoscopy that is a follow-up exam based on an initial screen when determined *medically necessary* by a provider. *Covered services* would be provided without *cost sharing* to the *member*. Pursuant to federal regulation, the no *cost share* does not apply to *member*s enrolled in an HSA-eligible plan. Please review your *Schedule of Benefits* to determine if your plan is HSA-eligible;
49. For elective sterilization procedures (e.g., vasectomies). **Note**: No *cost share* applies, except for HSA-compatible plans;
50. For an annual cervical or pap smear test for all *member*s. *Covered services* would be provided without *cost sharing* to the *member*. Pursuant to federal regulation, the no *cost share* does not apply to *member*s enrolled in an HSA-eligible plan. Please review your *Schedule of Benefits* to determine if your plan is HSA-eligible;
51. For *medically necessary covered services* including an annual prostate cancer screening when determined to be *medically necessary*. *Covered services* would be provided without *cost sharing* to the *member*. Pursuant to federal regulation, the no *cost share* does not apply to *member*s enrolled in an HSA-eligible plan. Please review your *Schedule of Benefits* to determine if your plan is HSA-eligible;
52. Coverage for children with neuromuscular, neurological, or cognitive impairment. *Covered services* include therapy, diagnostic testing, and equipment necessary to increase the quality of life for children who have been clinically or genetically diagnosed with any disease, syndrome, or disorder;
53. For testing, screening, and treatment services ordered by a pharmacist within the scope of that license or certification and the *covered services* are in accordance with *applicable law*;
54. Coverage for vaccinations for COVID-19, influenza, and respiratory syncytial virus. This includes the administration of the vaccine by a pharmacist or health care provider *authorized* to administer such a vaccine. *Covered services* would be provided without *cost sharing* to the *member*. Pursuant to federal regulation, the no *cost share* does not apply to *member*s enrolled in an HSA-eligible plan. Please review your *Schedule of Benefits* to determine if your plan is HSA-eligible;

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. Benefit precertification

5. *Physician* to *physician* consultation

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

Medical Dental Services

Anesthesia and hospital charges for dental care, for a *member* less than 19 years of age or a *member* who is physically or mentally disabled, are covered if the member requires dental treatment to be given in a hospital or outpatient *ambulatory surgical 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.

Coverage is also provided for:

1. *Medically necessary* oral surgery, including the following:
    a. Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
    b. Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jawbone and is medically necessary to attain functional capacity of the affected part.
    c. Oral/surgical correction of accidental injuries.
    d. Treatment for Temporomandibular Joint (TMJ) disorder, including removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services.
    e. Treatment of non-dental lesions, such as removal of tumors and biopsies.
    f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
    g. Surgical procedures that are *medically necessary* to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations. These services include oral and facial surgery, including reconstructive services and procedures necessary to improve, restore, or maintain vital functions:
        i. Dental implants, crowns, or bridges;
        ii. Prosthetic treatment such as obturators, speech appliances, and feeding appliances;
        iii. Orthodontic treatment and management;
        iv. Prosthodontic treatment and management; and
        v. Otolaryngology treatment and management.
    h. *Reconstructive surgery* to correct significant deformities caused by congenital or developmental abnormalities, *illness, injury* or an earlier treatment in order to create a more normal appearance.
    i. Removal of complete bony impacted teeth.

2. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* or office charges for dental care, rendered by a dentist, regardless of whether the services are provided in a network *hospital*, surgical center or office, provided to the following *members*:
    a. A *member* under the age of 19;
    b. A person who is severely disabled; or
    c. A person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.
3. For dental service expenses when a *member* suffers an *injury*, that results in:
    a. Damage to his or her natural teeth;
    b. *Injury* to the natural teeth will not include any injury as a result of chewing.
4. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, or malocclusions.

Medical Foods

We cover medical foods and formulas for:

1. outpatient total parenteral nutritional therapy;
2. nutritional counseling;
3. outpatient elemental formulas for malabsorption;
4. dietary formula (when *medically necessary* and prescribed by a network medical 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;
6. *medically necessary* amino acid-based elemental formula for the diagnosis and treatment of:
    a. eosinophilic disorders; and
    b. short bowel syndrome when prescribed by a physician.

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.

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

Exclusions:

No benefits will be paid for any other non-medical dietary formulas, oral nutritional supplements, special diets, prepared foods/meals and formula for access problems.

Medical Vision Services

Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by a *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 materials not specifically listed as a *covered service*.
3. Low vision services and hardware for adults.
4. Non-network care, except for re-authorized.

Mental Health and Substance Use Disorder Benefits

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

Covered services will be provided on an *inpatient* and outpatient basis and include mental health conditions. If you need mental health and/or *substance use disorder* treatment, you may choose any provider participating in our *behavioral health* network. You can search for network

behavioral health providers by accessing the “Find a Doctor” page at AmbetterHealth.com/en/IL 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 *member*s for the diagnosis and *medically necessary* treatment of mental, emotional, or *substance use disorder*s as defined in this *contract*.

When making coverage determinations, our *behavioral health* utilization management staff employ 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’s 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 behavioral health hospitalization does not require *prior authorization* for admission. Inpatient mental health hospitalization does not require concurrent review for the first 72 hours, provided the provider notifies us of both admission and the initial treatment plan within 48 hours of admission. Treatment may be reviewed retrospectively (after the first 72 hours), and if any coverage is denied, neither the insurer nor the *hospital* can bill the *member* for treatment through the date of the *adverse benefit determination*, other than any applicable *cost share*. Coverage will not be retrospectively denied for the first 72 hours of treatment at a participating *hospital* except:
    a. Upon determination that the inpatient mental health treatment was not provided;
    b. Upon determination that the patient receiving the treatment was not the *member*;
    c. Upon material misrepresentation by the patient or health care provider; and
    d. Upon determination the service was not a covered benefit under this *contract*.
2. Inpatient psychiatric hospitalization;
3. Inpatient detoxification treatment;
4. Inpatient rehabilitation;
5. Crisis stabilization;
6. Residential treatment facility for mental health and *substance use disorder*; and
7. Electroconvulsive therapy (ECT).

Outpatient

1. Outpatient services for the prevention, screening, diagnosis, or treatment of mental, emotional, nervous, or *substance use disorders* or conditions; *prior authorization not required*;
2. Partial Hospitalization Program (PHP);
3. Intensive Outpatient Program (IOP);
4. Mental health day treatment;
5. Outpatient detoxification programs;
6. Evaluation and assessment for mental health and *substance use disorder*;
7. Individual and group therapy for mental health and *substance use disorder*;
8. Medication assisted treatment – combines *behavioral health* therapy and medications to treat *substance use disorder*s;
9. Medication management services;
10. Psychological and neuropsychological testing and assessment;
11. *Applied behavior analysis*;
12. Telehealth (individual/family therapy; medication monitoring; assessment and evaluation);
13. Telepsychiatry
14. Electroconvulsive Therapy (ECT); and
15. *Transcranial Magnetic Stimulation (TMS)*.

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

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

Medically necessary telehealth services subject to the same clinical and *utilization review* criteria, plan requirements and limitations as the same health care services when delivered to an insured in person. *Telehealth services* provided through *Virtual 24/7 Care* vendors are subject to $0 *copay*. *Telehealth services* not provided through *Virtual 24/7 Care* vendors would be subject to the same *cost sharing* as the same health care services when delivered to an insured in-person. Pursuant to federal regulation, the $0 *cost share* does not apply to *member*s enrolled in an HSA-eligible plan. Please review your *Schedule of Benefits* to determine if your plan is HSA-eligible.

Outpatient and *inpatient* treatment provided for *substance use disorder*s require notification from the treating provider within 24 hours* of initiation of treatment. If the provider or facility fails to provide us with notification accordingly, *prior authorization* processes may be implemented. However, we will not require *prior authorization* for withdrawal management services or *inpatient* treatment services.

Note: *If the managed care organization is not capable of accepting the notification in accordance with the contractual protocol during the 24-hour period following admission, the substance use disorder treatment provider or facility shall have one additional business day to provide the notification to the appropriate managed care organization.

Inpatient mental health hospitalization does not require *prior authorization* for admission. *Inpatient* mental health hospitalization does not require concurrent review for the first 72 hours, provided the provider notifies us of both admission and the initial treatment plan within 48 hours of admission. Treatment may be reviewed retrospectively (after the first 72 hours), and if any coverage is denied, neither the insurer nor the *hospital* can bill the *member* for treatment through the date of the adverse determination, other than any applicable *cost share*. Coverage will not be retrospectively denied for the first 72 hours of treatment at a participating *hospital* except:

1. Upon determination that the *inpatient* mental health treatment was not provided;
2. Upon determination that the patient receiving the treatment was not the *member*;
3. Upon material misrepresentation by the patient or health care provider; and
4. Upon determination the service was not a covered benefit under this *contract*.

Pediatric Vision Expense Benefits

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

1. Routine ophthalmological 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. Low vision evaluation/aids
6. Contact lens fitting 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/en/IL 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*
4. Lasik *surgery*
5. Replacement eyewear.

Prescription Drug Expense Benefits

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

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

1. A *prescription drug*.
2. Prescribed, oral anticancer medication.
3. Any drug that, under the *applicable law*, may be dispensed only upon the written prescription of a *physician*.
4. Prescription inhalants as required by *applicable law*.
5. Select prescription vaginal estrogen without *cost share* as required by *applicable law*.
6. Prescription hormonal therapy, Human Immunodeficiency Virus Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP) as required by *applicable law*. *Covered services* would be provided without *cost sharing* to the *member*. Pursuant to federal regulation, the no *cost share* does not apply to *member*s enrolled in an HSA-eligible plan. Please review your *Schedule of Benefits* to determine if your plan is HSA-eligible.

7. 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.
8. Select prescribed prenatal vitamins as required by *applicable law*.

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

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

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

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*.

Non-Covered Services and Exclusions:

1. No benefits will be paid under this benefit provision for services provided or expenses incurred:
2. For *prescription drug* treatment of erectile dysfunction or any enhancement of sexual performance unless such treatment is listed on the *formulary*.
3. For weight *loss prescription drug*s unless otherwise listed on the *formulary*.
4. For immunization agents otherwise not required by the Affordable Care Act.
5. For medication that is to be taken by the *member*, in whole or in part, at the place where it is dispensed.
6. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
7. For a refill dispensed more than 15 months from the date of a *physician*'s order.
8. For more than the predetermined managed drug limitations assigned to certain drugs or classification of drugs.
9. 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*.
10. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.

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

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.

Special Rules for Prescription Drug Coverage:

The financial requirements applicable to orally administered cancer medications may be no different than those same requirements applied to intravenously administered or injected cancer medications.

Coverage for prescribed drugs for certain types of cancer shall not exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration if proper documentation, as outlined, is provided. Such coverage shall also include those *medically necessary* services associated with the administration of such drugs.

Inhaler Coverage

The total amount you will be required to pay for covered prescription inhalers, to enable persons to breathe when suffering from asthma or other life-threatening bronchial ailments, will not exceed any state and/or federally mandated limits.

Non-Formulary Prescription Drugs:

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

Formulary or Prescription Drug List

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

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

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the *formulary*. For the most current *formulary* or *prescription*

drug list or for more information about our pharmacy program, visit AmbetterHealth.com/en/IL or call Member Services.

Formulary includes coverage for opioid Medical Assisted Treatment (MAT) products, intranasal opioid reversal agents, topical anti-inflammatory medications for acute and chronic pain, and epinephrine injectors.

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.

Diabetic Care Expenses

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

How to Fill a Prescription

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

If you decide to have your *prescription order* filled at a network pharmacy, you can use the Provider Directory to find a pharmacy near you. You can access the Provider Directory at AmbetterHealth.com/en/IL on the “Find a Doctor” page. You can also call Member Services to help you find a pharmacy. At the pharmacy, you will need to provide the pharmacist with your *prescription order* and your *member* identification card.

We also offer a three-month (90-day) supply of maintenance medications by mail or from network retail pharmacies for specific benefit plans. These drugs treat long-term conditions or illnesses, such as high blood pressure, asthma and diabetes. You can find a list of covered medications on AmbetterHealth.com/en/IL. You can also request to have a copy mailed directly to you.

Extended Days' Supply

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

Split-Fill Dispensing Program

*Member*s are limited to 15-day supplies for the first 90 days when starting new therapy using certain medications (like oral oncology). *Member*s 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, *member*s 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.

Mail Order Pharmacy/Prescription Drug Delivery

Mail order pharmacy offers a convenient way to receive your prescriptions. Eligible prescriptions will be safely delivered right to your door at no extra charge to you. You will still be responsible for your regular *copayment*/*coinsurance*. To enroll for mail order delivery or for any additional questions, please refer to our website. Once on our website, you will find details on your in-network mail order pharmacies and next steps for enrollment.

Prescription Drug Synchronization

Under Illinois law, you have the right to request synchronization of your medications. Synchronization is alignment of your fill dates so that all of your medication-refill dates are on the same day. For example, if you fill medication A on the 5th of each month and your prescriber prescribes you a new prescription B on the 20th of the month, you have the right to request a refill for prescription B that is shorter or longer than 30 days. This may help you adjust your fill dates for medication B and synchronize the fill dates with medication A. We will adjust *Copays* to reflect shorter or longer coverage. If you would like to exercise this right, please call our customer service line.

Self-injectable Drugs

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

Prescription Drug Exception Process

Prescription drug exception process is applicable when:

1. The drug is not covered based on our *formulary*.
2. We are discontinuing coverage of the drug.
3. The generic drug or therapeutic equivalent is unavailable due to a supply issue until the generic drug is available.

Standard exception request

A *member*, a *member*'s *authorized representative* or a *member*'s prescribing *physician* may request a standard review of a decision that a drug is not covered by the plan. 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 be granted,

we will provide coverage of the non-formulary drug for the duration of the prescription, including refills.

Expedited exception request

A *member*, a *member*'s *authorized representative* or a *member*'s prescribing *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 request be granted, we will provide coverage of the non-formulary drug for the duration of the exigency.

External exception request review

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

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

Lock-In Program

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

Hereditary Bleeding Disorders

Drug therapies approved by the Food and Drug Administration (FDA) for the treatment of hereditary bleeding disorders do not require re-approval after initial authorization any more frequently than every six months or the length of time the prescription for that dosage remains valid, whichever period is shorter.

Third-Party Payments for Prescriptions

Any *third-party* payments, financial assistance, discount, product vouchers, or any other reduction in out-of-pocket expenses made by or on behalf of a *member* for *prescription drug*s will be applied to your *deductible*, *copayment*, *cost sharing* or *maximum out-of-pocket amount*.

Preventive Care Expense Benefits

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

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);
2. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC);
3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
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* or *copayment*). All preventive care services in the A and B recommendations found in the United States Preventive Services Task Force (USPSTF) guidelines are covered at no *cost-share* to the *member*.

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.

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/en/IL. To request a paper copy, please contact Member Services for assistance.

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

Notification

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

Covered Preventive Services for Adults including:

1. Abdominal aortic aneurysm one-time screening for men of specified ages (age 65-75) who have ever smoked;
2. Alcohol misuse screening and counseling;
3. Aspirin use for *member*s of certain ages;
4. Blood pressure screening for all adults;
5. Cholesterol screening for adults of certain ages or at higher risk;
6. Colorectal cancer screening for adults over age 45 (**Note**: screening should start before age 45 for high-risk individuals);
7. Depression screening for adults;
8. Diabetes screening for adults with high blood pressure;
9. Diet counseling for adults at higher risk for chronic disease;
10. HIV screening and counseling for all adults at higher risk;
11. Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
    a. Haemophilus influenza type b (HIB)
    b. Hepatitis A
    c. Hepatitis B
    d. Herpes Zoster
    e. Human Papillomavirus
    f. Influenza (Flu Shot)
    g. Measles, Mumps, Rubella
    h. Meningococcal
    i. Pneumococcal

j. Tetanus, Diphtheria, Pertussis

k. Varicella;

12. Obesity screening and counseling for all adults;

13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;

14. Tobacco or nicotine use screening for all adults and cessation interventions for tobacco or nicotine users;

15. Syphilis screening for all adults at higher risk;

16. Falls prevention in older adults, exercise or physical therapy. The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls;

17. Falls prevention in older adults: vitamin D. The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls;

18. Hepatitis B screening: non-pregnant adolescents and adults. The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection;

19. Hepatitis C virus infection screening: adults. The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965;

20. Lung cancer screening. The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung *surgery*;

21. Haemophilus influenza type b (HIB) one or three doses;

22. Skin cancer behavioral counseling. The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer;

23. Tuberculosis screening: adults. The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk

24. Whole body skin examination for the detection of skin cancer

25. Liver disease screening for adults ages 35 years to 65 years old that are at risk for liver disease. Coverage includes liver ultrasounds and alpha-fetoprotein blood tests every six months. *Covered services* would be provided without *cost sharing* to the *member*. Pursuant to federal regulation, the no *cost share* does not apply to *member*s enrolled in an HSA-eligible plan. Please review your *Schedule of Benefits* to determine if your plan is HSA-eligible.

26. Annual mental health prevention and wellness visits to:

a. Identify a mental health issue, condition, or disorder;

b. Discuss mental health symptoms that might be present, including symptoms of a previously diagnosed mental health condition or disorder;

c. Perform an evaluation of adverse childhood experiences; and

d. Discuss mental health and wellness.

Covered Preventive Services for Women and Pregnant Women include:

1. Anemia screening on a routine basis for pregnant *member*s;
2. Bacteriuria urinary tract or other infection screening for pregnant *member*s;
3. BRCA counseling and risk assessment about genetic testing for *member*s at higher risk;
4. One cytologic screening per year or more often if recommended by a *physician*;
5. Screening mammography for all *member*s over 35, baseline mammogram for *member*s 35 to 39 years of age and annual mammogram for *member*s 40 years of age and older, for *member*s under 40 with a family history of breast cancer or other risk factors mammograms are covered at an age and interval considered *medically necessary*, a comprehensive ultrasound screening of an entire breast or breasts when a mammogram demonstrates medical necessity as described, a screening MRI when *medically necessary*, as determined by a *physician*, and a *breast tomosynthesis*;
6. Breast cancer chemoprevention counseling for *member*s at higher risk;
7. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing *member*s;
8. Cervical cancer screening for sexually active *member*s;
9. Chlamydia infection screening for younger *member*s and other *member*s at higher risk;
10. Contraception: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling;
11. Domestic and interpersonal violence screening and counseling for all *member*s;
12. Folic Acid supplements for *member*s who may become pregnant;
13. Gestational diabetes mellitus screening. The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation;
14. Gonorrhea screening for all *member*s at higher risk;
15. Hepatitis B screening for pregnant *member*s at their first prenatal visit;
16. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active *member*s;
17. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for *member*s with normal cytology results who are 30 or older;
18. Coverage for *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis;

19. Pre-eclampsia prevention;
20. Rh Incompatibility screening for all pregnant *member*s and follow-up testing for *member*s at higher risk;
21. Tobacco or nicotine use screening and interventions for all *member*s, and expanded counseling for pregnant tobacco users;
22. Sexually Transmitted Infections (STI) counseling for sexually active *member*s;
23. Syphilis screening for all pregnant *member*s or other *member*s at increased risk;
24. Well-woman visits to obtain recommended preventive services; and
25. Ovarian cancer screening for *members* using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination.

Covered Preventive Services for Children including:

1. Alcohol and drug use assessments for adolescents;
2. Anticipatory Guidance: annually three years and older; more often if under three years;
3. Autism screening for children at 18 and 24 months;
4. Behavioral assessments for children through age 21;
5. Blood Pressure screening for children through age 21;
6. Cervical dysplasia screening for sexually active *member*s;
7. Congenital hypothyroidism screening for newborns;
8. Depression screening for adolescents;
9. Developmental screening for children under age three, and surveillance throughout childhood;
10. Dyslipidemia screening for children at higher risk of lipid disorders through age 21;
11. Fluoride chemoprevention supplements for children between six months and five years regardless of water source;
12. Gonorrhea preventive medication for the eyes of all newborns;
13. Hearing screening;
14. Height, weight and body mass index measurements for children through age 21;
15. Hematocrit or hemoglobin screening for children;
16. Hemoglobinopathies or sickle cell screening for newborns;
17. Hepatitis B screening: non-pregnant adolescents. The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection;
18. HIV screening for adolescents at higher risk;
19. Hypothyroid screening;

20. Immunization vaccines for children from birth to age 21—doses, recommended ages, and recommended populations vary:
    a. Diphtheria, Tetanus, Pertussis;
    b. Haemophilus influenzae type b;
    c. Hepatitis A;
    d. Hepatitis B;
    e. Human Papillomavirus;
    f. Inactivated Poliovirus;
    g. Influenza (Flu Shot);
    h. Measles, Mumps, Rubella;
    i. Meningococcal;
    j. Pneumococcal;
    k. Rotavirus;
    l. Varicella.
21. Intimate partner violence screening: women of childbearing age. The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse;
22. Iron supplements for children ages 6 to 12 months at risk for anemia;
23. Lead screening;
24. Medical history for all children throughout development through age 21;
25. Newborn blood screening;
26. Obesity screening and counseling;
27. Oral health risk assessment for children;
28. Phenylketonuria (PKU) screening for this genetic disorder in newborns;
29. Physical Examination Procedures: critical congenital heart defect screening newborn;
30. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
31. Skin cancer behavioral counseling. The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer;
32. Tobacco or nicotine use interventions: children and adolescents. The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco or nicotine use in school-aged children and adolescents;

33. Tuberculin testing for children at higher risk of tuberculosis through age 21;
34. Vision screening for all children; and
35. Whole body skin examination for the detection of skin cancer.
36. Annual mental health prevention and wellness visits to:
    a. Identify a mental health issue, condition, or disorder;
    b. Discuss mental health symptoms that might be present, including symptoms of a previously diagnosed mental health condition or disorder;
    c. Perform an evaluation of adverse childhood experiences; and
    d. Discuss mental health and wellness

Notification

As required by PHS Act section 2715(d)(4), we will provide 60 calendar days advance notice to you before any material modification will become effective, including any changes to preventive benefits covered under this *contract*.

You may access our website or the Member Services Department to get the answers to many of your frequently asked questions regarding preventive services. Our website has resources and features that make it easy to get quality care. Our website can be accessed at AmbetterHealth.com/en/IL.

Radiology, Imaging and Other Diagnostic Testing

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

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

Rehabilitation and Skilled Nursing Facility Expense Benefits

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

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

2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *skilled nursing facility* must be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *skilled nursing facility* for:
    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    c. Drugs and medicines that are prescribed by a *physician*, filled by a licensed pharmacist, and approved by the U.S. Food and Drug Administration.
4. *Covered service expenses* for non-provider facility services are limited to charges incurred for the professional services of *rehabilitation* licensed practitioners.
5. Outpatient physical therapy, occupational therapy, respiratory, pulmonary or inhalation therapy and speech therapy.
6. *Covered service* for physical therapy administered through *telehealth services*.
7. Coverage for preventive physical therapy for multiple sclerosis patients. As used here, “preventive physical therapy " means physical therapy that is prescribed by a physician licensed to practice medicine in all of its branches for the purpose of treating parts of the body affected by multiple sclerosis, but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.
8. Coverage for pulmonary *rehabilitation* therapy.
9. Coverage for cardiac outpatient *rehabilitation* services.

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

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

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

Second Medical Opinion

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

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

If requested, the second opinion consultation is to be provided by a *physician* of the *member*'s choice. The *member* must select a *network provider* listed in the Ambetter of Illinois Provider Directory. If a *member* chooses a *network provider*, he or she will only be responsible for the applicable *copayment amount* for the consultation. Any lab tests and/or diagnostic and therapeutic services are subject to additional *cost sharing*. The plan may allow a second opinion from a *non-network provider* which will be subject to *prior authorization* and medical necessity review.

Sleep Studies

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

Transplant Expense Benefits

Covered services for transplant service expenses:

1. Transplants are a *covered service* when a *member* is accepted as a transplant candidate and obtains *prior authorization* 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 transplant. We may require additional information such as testing and/or treatment before determining medical necessity for the transplant benefit. *Authorization* must be obtained prior to performing any related services to the transplant *surgery*. Transplant services must meet medical criteria as set by Medical Management Policy (as found on our website at AmbetterHealth.com/en/IL).
2. *Cost share* benefit coverage related to transplant services is available to both the recipient and donor of a covered transplant as follows:
3. If both the donor and recipient have coverage provided by the same insurer each will have their benefits paid by their own coverage program.
4. If you are the recipient of the transplant, 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 the *member*'s benefits.
5. 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.
6. If lapse in coverage due to non-payment of premium, no services related to transplants will be paid as a *covered service*.

After *prior authorization* for a *member* and donor as appropriate candidates for a *medically necessary* transplant is received, live donation, *covered service expenses* will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting of the organ from the donor.
3. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).

4. Including outpatient *covered services* related to the transplant *surgery*; pre-transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection, and other immunosuppressant 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 visits and treatments.
8. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.
9. All costs incurred and medical expenses by the donor; shall be paid under the transplant recipient policy, this excludes travel, lodging, food, and mileage.

Please refer to the “Member Transplant Travel Reimbursement Policy” for outlined details on reimbursement limitations at https://www.ambetterhealth.com/en/il/resources/handbooks-forms/.

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

Ancillary "Center of Excellence" Service Benefits:

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

1. We will pay for the following services when the *member* is required to travel more than 50 miles from the *residence* to the *Center of Excellence*.
2. We will pay a maximum of $10,000 per transplant service for the following services:
    a. Transportation for the *member*, any live donor, and the companion(s) to accompany the *member* to and from the *Center of Excellence*, in the United States. If the recipient is an *eligible child*, we will cover transportation for two companion(s) to accompany the child.
    b. When the *member* and/or companion(s) is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
    c. Maximum reimbursement for mileage is limited to the total miles traveled by the transplant recipient and by the donor and their respective companion(s), to and from their respective home to the transplant facility, plus miles traveled:
        i. Between the transplant facility and local lodging; and
        ii. Between a transit hub (e.g., airport, train station, bus station) and either the transplant facility or local lodging.

d. Lodging at or near the *Center of Excellence* for any live donor and the companion(s) accompanying the *member* while the *member* is confined in the *Center of Excellence* in the United States. We will reimburse *member*s for the proof of costs directly related to transportation, lodging and any of the following approved items listed in the *member* transplant reimbursement guidelines. However, you must make the arrangements and provide the necessary paid receipts for reimbursement within 6 months of the date of service in order to be reimbursed.

Please refer to the Member Resources page for *member* reimbursement transplant travel forms and information at AmbetterHealth.com/en/IL.

Non-Covered Services and Exclusions:

1. No benefits will be provided or paid under these transplant expense benefits:
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.
3. For animal to human transplants.
4. To keep a donor alive for the transplant operation, except when *authorized* through the *Center of Excellence*.
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the *Center of Excellence*.
6. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
7. Related to transplants unauthorized through the *Center of Excellence* and is not included under this provision as a transplant.
8. For a transplant under study in an ongoing phase I or II clinical trial as set forth in FDA regulation, regardless of whether the trial is subject to FDA oversight.
9. The acquisition cost for the organ or bone marrow, when provided at an unauthorized facility or not obtained through the *Center of Excellence*.
10. For any transplant services and/or travel related expenses for the *member* and donor, when performed outside of the United States.
11. The following ancillary items listed below, will not be subject to *member* reimbursement under this *contract*:
    a. Alcohol/tobacco
    b. Car, trailer, or truck rental (unless pre-approved by Case Management)
    c. Vehicle maintenance for motorized, hybrid, and electric cars (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 or parking tickets

j. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)

k. Any services related to pet care, boarding, lodging, food, and/or travel expenses.

l. Expenses for persons other than the transplant recipient, donor or their respective companion(s).

m. Expenses for lodging when the transplant recipient, donor, or their respective companion(s) are staying with a relative, friend, or otherwise have free lodging.

n. Any expense not supported by a receipt

o. Upgrades to first class travel (air, bus, and train)

p. Personal care items (e.g., shampoo, deodorant, clothes)

q. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA pre-check, and early check-in boarding fees, extra baggage fees.

r. Souvenirs (e.g., t-shirts, sweatshirts, toys)

s. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type.

t. All other items not described in this *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, facility, or other provider.

Urgent Care

Urgent care services include *medically necessary* services by *network provider*s 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*.

*Member*s are encouraged to contact their *PCP* for an appointment before seeking care from another provider, but network *urgent care center*s and walk in clinics can be used when an urgent appointment is not available. If the *PCP* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-855-745-5507 (TTY 1-844-3431). The 24/7 Nurse Advice Line is available 24 hours a day, seven days a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

WELLNESS PROGRAMS AND OTHER OFFERINGS

In connection with this *contract*, we may offer wellness programs and other services to *member*s 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 *member*s. 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 services may vary within your market. To inquire about these programs and other offerings, and to learn about what programs are available in your area, please visit our website at AmbetterHealth.com/en/IL 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*. *Member*s may receive communications and outreach about this program. Ambetter reserves the right to apply any such rewards to any unpaid premium or related amounts you may owe.

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

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

You can access other services in connection with this *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. *Member*s are responsible for paying for the discounted goods or services and we do not endorse any vendor, goods or services associated with the program. *Member*s may also have access to a zero-interest line of credit through the Ambetter Perks program for paying their *deductibles*, *copayments*, and *coinsurance* on *covered services*, with several repayment options to fit their needs. The Ambetter Perks program is offered to all *member*s. We are not involved in administering programs; you will communicate directly with any vendors if you choose to participate.

PRIOR AUTHORIZATION

Ambetter of Illinois insured by Celtic Insurance Company 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.
2. Concurrent review – occurs when a medical service is reviewed as it happens (e.g., *inpatient* stay or *hospital* admission).
3. Retrospective review – occurs after a service has already been provided.

Prior Authorization Required

Some medical and *behavioral health covered service expenses* require *prior authorization*. In general, *network provider*s 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 *prior authorization*.

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

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

1. At least 5 calendar days prior to an elective admission as an *inpatient* in a *hospital*, extended care or *rehabilitation facility*, or *hospice* 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, including emergent *inpatient* admissions.
5. At least 5 calendar days prior to the start of *home health care* except those *member*s needing *home health care* after *hospital* discharge.

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 48 hours of receipt of all information necessary.

2. For urgent pre-service reviews, within 48 hours from the date of receipt of all information necessary to make a determination.
3. For non-urgent pre-service reviews, within 5 calendar days of receipt of the request.
4. For post-service or retrospective reviews, within 30 calendar days of receipt of the request.

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

If your *prior authorization* request has been denied, please refer to the Internal Grievance, Appeals, and External Review Procedures section of this *contract* for information on your right to appeal a denied *authorization*.

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. There is a penalty if treatment is not *authorized* prior to service. The penalty is a 20 percent reduction of the *eligible expenses* for all charges related to the treatment, not to exceed $1,000. The penalty applies to all otherwise *eligible expenses* that are:

1. Incurred for treatment without *prior authorization*;
2. Incurred during additional *hospital* days without *prior authorization*; or
3. Determined to be inappropriately *authorized* following a retrospective review, or inappropriately *authorized* due to intentional misrepresentation of facts or false statements.

*Network provider*s 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*.

If we *authorize* a proposed admission, treatment, or *covered service* expense by a *network provider* based upon the complete and accurate submission of all necessary information relative to an eligible *member*, we shall not retroactively deny this *authorization* if the *network provider* renders the *covered service* expense in good faith and pursuant to the *authorization* and all of the terms and conditions of the *network provider*'s *contract* with us.

Transition of Services

We shall notify new *member*s and current *member*s of the availability of transitional services for conditions that require an ongoing course of treatment.

New *member*s must request the option of transitional services in writing, within 15 calendar days after receiving notification of the availability of transitional services.

*Member*s whose *physician* leaves the network of health care providers shall request the option of transitional services in writing within 30 calendar days after receipt of notification of termination of the *physician*.

Within 15 calendar days after receiving such notification from the *member*, we shall notify the *member* if a denial is issued for the *member*'s request of transitional services based on the *member*'s *physician* refusing to agree to accept our plan's reimbursement rates, adhere to the our plan's quality assurance requirements, provide our plan with necessary medical information related to the *member*'s care, or otherwise adhere to our plan's policies and procedures. The notification shall be in writing and includes the specific reason for such denial.

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

If you receive emergent services from a *non-network provider*, you are responsible for an amount equal to your responsibility for similar services provided by a *network provider*. If you believe you have been billed in error, please contact Member Services.

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *member* in the absence of insurance covering the charge.
2. Expenses, fees, taxes or surcharges imposed on the *member* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.
3. Any services performed by a *member* of the *member*'s *immediate family*.
4. Any services not identified and included as *covered service expenses* under the *contract*. You will be fully responsible for payment for any services that are not *covered service expenses*.
5. Any services where other coverage is primary to Ambetter must be first paid by the primary payor prior to consideration for coverage under Ambetter.

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*.
2. For any portion of the charges that are in excess of the *eligible expense*.
3. For cosmetic breast reduction or augmentation, except for *medically necessary*.
4. For weight *loss* programs, gym memberships, exercise equipment, or meal preparation programs.
5. For the reversal of sterilization and reversal of vasectomies.
6. For expenses for television, telephone, or expenses for other persons.
7. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
8. For telephone consultations between providers, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
9. For stand-by availability of a *medical practitioner* when no treatment is rendered.
10. For dental service expenses, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Major Medical Service Expense Benefits section.

11. 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.
12. For mental health exams and services involving:
    a. School funded/administered services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
    b. Pre-marital counseling;
    c. Court-ordered care or testing or required as a condition of parole or probation. Benefits will be allowed for services that are *medically necessary* and would otherwise be covered under this *contract*;
    d. Testing of aptitude, ability, intelligence or interest; and
    e. Evaluation for the purpose of maintaining employment. Benefits will be allowed for services that would otherwise be covered under this *contract*.
13. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
14. For services while confined primarily to receive *custodial care* or nursing services (unless expressly provided for in this *contract*).
15. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*. Coverage for eyeglasses is listed under Outpatient Medical Supplies Expense Benefits, Pediatric Vision Expense Benefits, and Vision Expense Benefits.
16. For *experimental or investigational* treatment(s). The fact that an *experimental or investigational* treatment 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 for the treatment of that particular condition.
17. For treatment received outside the United States, except for a medical emergency.
18. For fetal reduction *surgery*.
19. Except as specifically identified as a *covered service* expense under the *contract*, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
20. For *prescription drug*s 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.

21. For the following miscellaneous items: artificial insemination (except where required by federal or state law); chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods provision; health club memberships, unless otherwise covered; home test kits, unless required by *applicable law*; care or services provided to a non-member biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *rehabilitation* services for the enhancement of job, athletic or recreational performance; routine or elective care outside the *service area*; transportation expenses, unless specifically described in this *contract*.
22. For any non-*medically necessary* court ordered care for a medical/surgical or mental health/*substance use disorder* diagnosis, unless required by state law.
23. For domiciliary care provided in a residential institution, treatment center, halfway house, or school because a *member*'s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
24. For services or care provided or billed by a school, *custodial care* center for the developmentally disabled.
25. For diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
26. 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.
27. For any medicinal and recreational use of cannabis or marijuana.
28. For immunizations that are not *medically necessary* or medically indicated. This includes those used for travel and occupational purposes.
29. For expenses, services, and treatments from a massage therapist to touch and manipulate the muscles and other soft tissues of the body.
30. For expenses, services, and treatments from a naturopathic specialist for treatment or prevention, self-healing and use of natural therapies.
31. For expenses, services, and treatments related to private duty nursing on an *inpatient* basis.
32. For expenses for services related to dry needling.
33. For Assertive Community Treatment (ACT)
34. 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.
35. For s*urrogacy 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. Any complications of the *surrogate* resulting from the *pregnancy*;

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

g. Coverage for a *surrogate* up to the release to regular care once *pregnancy* has been attained.

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 moment of birth.

Exceptions to Limitations:

1. This *contract* will not deny *medically necessary* breast implant removal for an *illness* or *injury*. However, this exception will not apply to the removal of breast implants that were done solely for cosmetic purposes.
2. This *contract* will not deny or exclude coverage for fibrocystic breast condition in the absence of a breast biopsy demonstrating an increased disposition to the development of breast cancer unless the covered person's medical history is able to confirm a chronic, relapsing, symptomatic breast condition.

TERMINATION

Termination of Contract

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

1. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *contract* (including, but not limited to, the Grace Period provision) or the date that we have not received timely premium payments in accordance with the terms of this *contract*.
2. The date of termination that GetCovered Illinois provides us upon your request of cancelation.
3. For a dependent child reaching the limiting age of 26, coverage under this *contract*, for a dependent child, will terminate at 11:59 p.m. on the last day of the year in which the dependent child reaches the limiting age of 26.
4. The date we decline to renew this *contract*, as stated in the discontinuance provision of this *contract*.
5. The date of your death, if this *contract* is an individual plan.
6. The date a *member*'s eligibility for coverage under this *contract* ceases as determined by GetCovered Illinois; or
7. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact.

Refund upon Cancellation

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

Discontinuance

90-Day Notice: If we discontinue offering all *contracts* issued on this form, with the same type and level of benefits, for all residents of the state 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 *contracts* 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 *contracts* in the individual market in the state where you reside.

Notification Requirements

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

Reinstatement

If any premium is not paid by the end of the grace period your coverage will terminate. Later acceptance of premium by us, within four calendar days of the end of the grace period, will reinstate your *contract* with no break in your coverage. We will refund any premium that we receive after this four-day period.

Reinstatement shall not change any provisions of the *contract*.

SUBROGATION AND RIGHT OF REIMBURSEMENT

As used herein, the term "*third-party*", means any party that is, or may be, or is claimed to be responsible for *illness* or injuries to you. Such *illness* or injuries are referred to as "*third-party* injuries." "*Third-party*" includes any party responsible for payment of expenses associated with the care of treatment of *Third-party* Injuries.

If this plan pays benefits under this *contract* to you for expenses incurred due to *Third-party* Injuries, then to the extent permissible by law Ambetter of Illinois retains the right to repayment of the full cost of all benefits provided by this plan on your behalf that are associated with the *Third-party* Injuries. Ambetter of Illinois's rights of recovery apply to any recoveries made by or on your behalf from the following sources, including, but not limited to:

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

By accepting benefits under this plan to the extent permissible by law, you specifically acknowledge Ambetter of Illinois's right of subrogation. When this plan pays health care benefits for expenses incurred due to *third-party* injuries, Ambetter of Illinois shall be subrogated to your right of recovery against any party to the extent of the full cost of all benefits provided by this plan. Ambetter of Illinois may proceed against any party with or without your consent.

By accepting benefits under this plan to the extent permissible by law, you also specifically acknowledge Ambetter of Illinois's right of reimbursement. This right of reimbursement attaches when this plan has paid benefits due to *third-party* injuries and you or your representative has recovered any amounts from a *third-party*. By providing any benefit under this *contract*, Ambetter of Illinois is granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by this plan. Ambetter of Illinois right of reimbursement is cumulative with and not exclusive of Ambetter of Illinois subrogation right and Ambetter of Illinois may choose to exercise either or both rights of recovery.

By accepting benefits under this plan, you or your representatives further agree to the extent permissible by law to:

1. Notify us promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to *third-party* injuries sustained by you.
2. Cooperate with us and do whatever is necessary to secure our rights of subrogation and reimbursement under this *contract*.

3. Give Ambetter of Illinois a first-priority lien on any recovery, settlement, or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with *third-party* injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
4. Pay, as the first priority, from any recovery, settlement judgment, or other source of compensation, any and all amounts due Ambetter of Illinois as by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by Ambetter of Illinois in writing; and
5. Do nothing to prejudice Ambetter of Illinois rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the plan.
6. Serve as a constructive trustee for the benefits of this plan over any settlement or recovery funds received as a result of *third-party* injuries.

Ambetter of Illinois may recover full cost of all benefits paid by this plan under this *contract* without regard to any claim of fault on your part, whether by comparative negligence or otherwise. In the event you or your representative fail to cooperate with Ambetter of Illinois, you shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by Ambetter of Illinois in obtaining repayment.

CLAIMS

Notice of Claim

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

Proof of Loss

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

How to Submit a Claim

*Network provider*s are contractually required to submit claims directly to us on your behalf for *covered services*, but sometimes you may need to submit claims yourself for *covered services*. This may happen if your provider is not contracted with us.

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

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

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

In situations where *network provider*s are contractually required to submit claims directly to us on your behalf for *covered services*, you will not receive from us an acknowledgement of the claim submission, notices and explanations for claim delays, or notice of recourse available through contacting the Illinois Department of Insurance.

Time for Payment of Claims

Benefits will be paid within 30 calendar days after receipt of *proof of loss*. Should we determine that additional supporting documentation is required to establish responsibility of payment, we shall pay benefits within 30 calendar days after receipt of *proof of loss*. If we do not pay within such period, we shall pay interest at the rate of nine percent per annum from the 30th day after receipt of such *proof of loss* to the date of late payment.

Payment of Claims

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

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

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

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 (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 Status must be submitted with the claim. These documents must be submitted with the Member Reimbursement Medical Claim Form, along with all requested documents as detailed on the claim form. All forms and *member* resources are available at AmbetterHealth.com/en/IL.

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.

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.

Post Stabilization Services

Timely determination shall mean a determination is made within 30 calendar days after we receive a claim for post stabilization services if no additional information is needed to determine that services rendered were not contrary to our instructions. In the event additional information is necessary to make such a determination, we shall request the medical record documenting the time, phone number dialed, and the result of the communication for request for *authorization* of post stabilization medical services as well as the post stabilization medical services rendered within 15 calendar days after receipt of the post stabilization services claim and make a determination within 30 calendar days after its receipt.

Reimbursement for covered post-stabilization procedures shall be provided if we approve *authorization* for the services rendered. Reimbursement shall also be provided if, after two documented good faith efforts, the provider has attempted to contact us for *prior authorization* of post stabilization medical services, and we were not accessible or did not deny the *authorization* within 60 minutes of the request. As used in this section, “two documented good faith efforts” means the health care provider has called the telephone number on the *member's* health insurance card or other available number either 2 times or one time and an additional call to any referral number provided and "good faith" means honesty of purpose, freedom from intention to defraud, and being faithful to one's duty or obligation.

Legal Actions

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

No action at law or in equity may be brought against us under the *contract* for any reason unless the *member* first completes all the steps in the *complaint*/*appeal* procedures made available to resolve disputes in your state under the *contract*. After completing that *complaint/appeal* procedures process, if you want to bring legal action against us on that dispute, you must do so within three years of the date we notified you of the final decision on your *complaint/appeal*.

Grievance Process

A *grievance* or *complaint* is an expression of dissatisfaction regarding our products or services. You or your *authorized representative* may submit a *grievance* verbally or in writing. Depending on the nature of the *grievance* and whether or not a response is requested, we will respond verbally and/or in writing within 60 business days following receipt of the *grievance* or should a *member*'s medical condition necessitate an expedited review, a response within 24 hours. We may extend the response time for up to an additional 30 calendar days in the event additional information is required.

The response will state the reason for our decision and inform the *member* of the right to pursue a further review and explain the procedures for initiating such review. *Grievances* will be considered when measuring the quality and effectiveness of our products and services.

Coordination of Benefits with a Medicare plan

If a *member* and/or *dependent member* is enrolled in Medicare and Ambetter of Illinois insured by Celtic Insurance Company, Medicare will be the primary payer and Ambetter of Illinois insured by Celtic Insurance Company will be the secondary payer. Ambetter of Illinois insured by Celtic Insurance Company will not pay benefits until after Medicare has paid its share of the costs. Ambetter of Illinois insured by Celtic Insurance Company will reimburse part or all of the allowable expense left unpaid. The *member* will be responsible for the remaining out-of-pocket expenses as applicable.

A *member* or *dependent member* enrolled in Ambetter of Illinois insured by Celtic Insurance Company and Medicare is required to notify GetCovered Illinois. The *member*'s profile will be updated to indicate the *member* has Medicare coverage. *Member*s may no longer be eligible to receive a premium subsidy for GetCovered Illinois plan once Medicare coverage becomes effective.

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.

INTERNAL GRIEVANCE, APPEALS, AND EXTERNAL REVIEW PROCEDURES
INTERNAL PROCEDURES

Applicability/Eligibility

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

Call Member Services

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

COMPLAINTS, GRIEVANCES, & APPEALS

Complaints

Basic elements of a *complaint* include:

1. The complainant is the claimant or an *authorized representative* of the *member*;
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 *complaint*s - “the person to whom I spoke on the phone was rude to me”;
    b. Providers with whom we have a *contract*;
        i. Lack of availability and/or accessibility of *network provider*s not tied to an unresolved benefit denial; and
        ii. Quality of care/quality of service issues;
4. Written expressions of dissatisfaction regarding quality of care/quality of service are processed as *grievances*;
5. Oral expressions of dissatisfaction regarding quality of care/quality of service are processed as complaints as indicated in standard oral *complaint* instructions; and
6. Any of the issues listed as part of the definition of *grievance* received from the *member* or the *member*’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.

Grievances

Grievances may be filed by:

1. A *member*;

2. A person *authorized* to act on behalf of the *member*.

Note: Written *authorization* is not required; however, if received, we will accept any written expression of *authorization* without requiring specific form, language, or format.

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

1. Provision of services;
2. Determination of a diagnosis or level of service required for evidence-based treatment of *autism spectrum disorders*;
3. Claims practices;
4. Is unable to give consent: a *spouse*, family *member*, or the treating provider; or
5. In the event of an *expedited appeal*: the person for whom the insured has verbally given *authorization* to represent the *member*.

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

Appeals

Appeals may be filed by:

1. A *member*;
2. The *member*'s provider; or
3. A person *authorized* to act on behalf of the *member*.

A *member* has a right to file a *grievance* and/or *appeal* review. *Member*s have the right to submit written comments, documents, records, and other information relating to the claim for benefits. An *adverse benefit determination* must be *appealed* within 180 calendar days. *Member*s have the right to review the claim file and to present evidence and testimony as part of the internal review process. The *grievance* and/or *appeal* should be sent to the following address:

Ambetter of Illinois
Attn.: Appeals and Grievances
P.O. Box 10341
Van Nuys, CA 91410
Phone # 1-855-745-5507
TTY 1-844-517-3431
Fax # 1-833-886-7956

A *member* has the right to request an internal review in tandem with a provider's request for an expedited internal review or a concurrent review is in process.

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

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

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

Resolution Timeframes

1. *Grievances* regarding quality of care, quality of service, or reformation will be resolved within 30 calendar days of receipt. The time period may be extended for an additional 30 calendar days, making the maximum time for the entire *grievance* process 60 calendar days if we provide the *member* and the *member*'s *authorized representative*, if applicable, written notification of the following within the first 30 calendar days:
   a. That we have not resolved the *grievance*;
   b. When our resolution of the *grievance* may be expected; and
   c. The reason why the additional time is needed.
2. *Appeals* regarding *adverse benefit determinations* will be resolved within 15 business days The party who filed the *appeal* shall be notified within three business days of all information required to evaluate the *appeal*, and once provided, we will notify the *member*, party filing *appeal*, and the *member*'s *PCP* in writing of the *appeal* decision. The time period to resolve the *appeal* may be extended for an additional 15 calendar days, if we provide the *member* and the *member*'s *authorized representative*, if applicable, written notification of the following within the first 15 business days:
   a. That we have not resolved the *appeal*;
   b. When our resolution of the *appeal* may be expected; and
   c. The reason why the additional time is needed.

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

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

Grievance Committee

Within ten calendar days of receipt of the initial internal *grievance* resolution letter, the *member* has the right to request a Grievance Committee hearing if they do not agree with the decision. The Grievance Committee membership will consist of 50 percent active *member* membership and will conduct the hearing within 2 weeks (or 14 calendar days) from the receipt of request. The Grievance Committee shall meet at our main office, or other office designated by us if the main office is not within 50 miles of the *member*'s home address, if the *member* wishes to attend in person. The Grievance Committee may also meet virtually, if more convenient for the *member*. The Grievance Committee coordinator will work with a *member* to determine a mutually agreed upon date and time for the panel hearing. The *member* shall have the right to attend and participate in the formal *grievance* proceedings, and the right to be represented by a designated representative of his or her choice.

The *member* has the right to review the information, as outlined in the *member*'s rights, that was used to make the initial determination and has the right to supply any additional information which the *member* would like the Grievance Committee to review as part of their final and binding decision. A written decision from the Grievance Committee shall be provided within 60 calendar days from receipt of the original *grievance*. The determination by the Grievance Committee may be extended for a period not to exceed 30 calendar days in the event of a delay in obtaining the documents or records necessary for the resolution of the *grievance*.

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 *member* and us by telephone, facsimile, or other available similarly expeditious method.

An *expedited appeal* shall be resolved as expeditiously as the *member*'s health condition requires but not more than 24 hours after receipt of the *grievance*.

Due to the 24-hour resolution timeframe, the standard requirements for notification, *grievance* panel, and acknowledgement do not apply. The provider who recommended the service and/or the *member*'s *PCP*, along with the *member*, shall be notified orally of the decision followed-up by a written notice of the determination.

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

Written Grievance and Appeal Responses

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

The written decision to the grievant/appellant must include (if applicable):

1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *grievance* or *appeal*;
3. The signature of one voting *member* of the Grievance Committee; and
4. A written description of position titles of panel *member*s involved in making the decision.
5. If upheld or partially upheld, it is also necessary to include (if applicable):
    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 *member*'s claim for benefits;
    d. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
    e. If the *adverse benefit determination* is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant 's medical circumstances, or a statement that such explanation will be provided free of charge upon request.;
    f. Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse benefit determination*;

g. The date of service;

h. The health care provider's name;

i. The claim amount;

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

k. The health plan's denial code with corresponding meaning;

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

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

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

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

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

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

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 member 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. Ambetter of Illinois must respond to Insurance Department complaints within 21 calendar days from receipt.

You may file a consumer complaint online at the Illinois Department of Insurance's website or by mail.

The Department maintains a Consumer Division in Chicago at:
Illinois Department of Insurance
115 S. LaSalle Street, 13th Floor
Chicago, IL 60603
Phone number: (312) 814-2420

and in Springfield at:
Office of Consumer Health Insurance
320 W. Washington Street
Springfield, IL 62767
Toll-free Phone No. 1-877-527-9431
Facsimile No. 1-217-558-2083
DOI.complaints@illinois.gov
https://idoi.illinois.gov/consumers/file-a-complaint.html

External Review

An external review decision is binding on us. An external review decision is binding on the *member* 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.

If we have denied your request for the provision of or payment for a health care service or course of treatment, you have the right to have our decision reviewed by an independent review organization not associated with us.

Applicability/Eligibility

External review is available for *grievances* that involve:

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

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

1. The internal *appeal* process must be exhausted before the *member* may request an external review unless the *member* files a request for an expedited external review at the same time as an internal *expedited appeal* or we either provide a waiver of this requirement or fail to follow the *appeal* process;
2. A health plan must allow a claimant to make a request for an expedited external review with the plan at the time the *member* receives:
    a. An *adverse benefit determination* if the determination involves a medical condition of the *member* for which the timeframe for completion of an internal *expedited appeal* would seriously jeopardize the life or health of the *member* or would jeopardize the *member*'s ability to regain maximum function and the *member* has filed a request for an internal *expedited appeal*; and

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

3. *Member*s may request an expedited external review at the same time the internal *expedited appeal* is requested, and an Independent Review Organization (IRO) will determine if the internal *expedited appeal* needs to be completed before proceeding with the expedited external review.

External Review Process

Request for External Review

A *member* or the *member*'s *authorized representative* may make a request for a standard external or expedited external review of an adverse determination or final adverse determination. Any pertinent additional information may be submitted with the request for standard or expedited external review.

Exhaustion of Internal Appeal Process

For urgent situations, a *member* shall skip the internal *appeal* and standard review process and request an expedited external review.

A request for an external review shall not be made until the *member* has exhausted our internal *appeal* process. A *member* shall be considered to have exhausted our internal *appeal* process if:

1. the *member* or the *member*'s *authorized representative* has filed an *appeal* under our internal *appeal* process and has not received a written decision on the *appeal* 15 business days following the date the *member* or the *member* 's *authorized representative* files an *appeal* of an adverse determination that involves a concurrent or prospective review request or 15 business days following the date the *member* or the *member*'s *authorized representative* files an *appeal* of an adverse determination that involves a retrospective review request, except to the extent the *member* or the *member*'s *authorized representative* requested or agreed to a delay;
2. the *member* or the *member*'s *authorized representative* filed a request for an *expedited appeal* of an adverse determination and has not received a decision on such request from us within 48 hours, except to the extent the *member* or the *member*'s *authorized representative* requested or agreed to a delay;
3. We agree to waive the exhaustion requirement;
4. the *member* has a medical condition in which the timeframe for completion of (A) an *expedited appeal* involving an adverse determination, (B) a final adverse determination, or (C) a standard external review would seriously jeopardize the life or health of the *member* or would jeopardize the *member*'s ability to regain maximum function;

5. an adverse determination concerns a denial of coverage based on a determination that the recommended or requested health care service or treatment is *experimental or investigational* and the *member*'s health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated; in such cases, the *member* or the *member*'s *authorized representative* may request an expedited external review at the same time the *member* or the *member*'s *authorized representative* files a request for an expedited internal *appeal* involving an adverse determination; the independent review organization assigned to conduct the expedited external review shall determine whether the *member* is required to complete the expedited review of the *appeal* prior to conducting the expedited external review; or
6. We have failed to comply with *applicable law* governing internal claims and *appeals* procedures.

Standard External Review

Within four months after the date of receipt of a notice of an adverse determination or final adverse determination, a *member* or the *member*'s *authorized representative* may file a request for an external review with the Director. Within one business day after the date of receipt of a request for external review, the Director shall send a copy of the request to us. The addresses for the Director of Insurance follow:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 W. Washington Street
Springfield, IL 62767
(877) 850-4740 Toll-free phone
(217) 557-8495 Fax number
Doi.externalreview@illinois.gov
https://idoihelpcenter.illinois.gov/s/

Within five business days following the date of receipt of the external review request, we shall complete a preliminary review of the request to determine whether:

1. the individual is or was a *member* at the time the health care service was requested or at the time the health care service was provided;
2. the health care service that is the subject of the adverse determination or the final adverse determination is a *covered service* under the *member*'s health benefit plan, but we have determined that the health care service is not covered;
3. the *member* has exhausted our internal *appeal* process unless the *member* is not required to exhaust our internal *appeal* process pursuant to this act; and
4. the *member* has provided all the information and forms required to process an external review, as specified in this act.

If the request:

1. is not complete, we shall inform the Director and *member* and, if applicable, the *member*'s *authorized representative* in writing and include in the notice what information or materials are required by this Act to make the request complete; or
2. is not eligible for external review, we shall inform the Director and *member* and, if applicable, the *member*'s *authorized representative* in writing and include in the notice the reasons for its ineligibility.

The notice of initial determination of ineligibility shall include a statement informing the *member* and, if applicable, the *member*'s *authorized representative* that our initial determination that the external review request is ineligible for review may be objected to the Director by filing a *complaint* with the Illinois Department of Insurance.

Notwithstanding our initial determination that the request is ineligible for external review, the Director may determine that a request is eligible for external review and require that it be referred for external review.

Whenever the Director receives notice that a request is eligible for external review following the preliminary review conducted, within one business day after the date of receipt of the notice, the Director shall:

1. assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Director and notify us of the name of the assigned independent review organization; and
2. notify in writing the *member* and, if applicable, the *member*'s *authorized representative* of the request's eligibility and acceptance for external review and the name of the independent review organization.

The Director shall include in the notice provided to the *member* and, if applicable, the *member*'s *authorized representative* a statement that the *member* or the *member*'s *authorized representative* may, within five business days following the date of receipt of the notice provided, submit in writing to the assigned independent review organization additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five business days.

The assignment by the Director of an approved independent review organization to conduct an external review shall be done on a random basis among those independent review organizations approved by the Director.

Within five business days after the date of receipt of the notice provided, we or our designee *utilization review* organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination; in such cases, the following provisions shall apply:

1. Except as provided, failure by us or our *utilization review* organization to provide the documents and information within the specified time frame shall not delay the conduct of the external review.

2. If we or our *utilization review* organization fails to provide the documents and information within the specified time frame, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.
3. Within one business day after making the decision to terminate the external review and make a decision to reverse the adverse determination or final adverse determination, the independent review organization shall notify the Director, us, the *member* and, if applicable, the *member*'s *authorized representative*, of its decision to reverse the adverse determination.

Upon receipt of the information from us or our *utilization review* organization, the assigned independent review organization shall review all of the information and documents and any other information submitted in writing to the independent review organization by the *member* and the *member*'s *authorized representative*.

Upon receipt of any information submitted by the *member* or the *member*'s *authorized representative*, the independent review organization shall forward the information to us within one business day.

Upon receipt of the information, if any, we may reconsider its adverse determination or final adverse determination that is the subject of the external review.

Reconsideration by us of our adverse determination or final adverse determination shall not delay or terminate the external review.

The external review may only be terminated if we decide, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination. In such cases, the following provisions shall apply:

1. Within one business day after making the decision to reverse its adverse determination or final adverse determination, we shall notify the Director, the *member* and, if applicable, the *member*'s *authorized representative*, and the assigned independent review organization in writing of its decision.
2. Upon notice from us that we have made a decision to reverse its adverse determination or final adverse determination, the assigned independent review organization shall terminate the external review.

In addition to the documents and information provided by us or our *utilization review* organization and the *member* and the *member*'s *authorized representative*, if any, the independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

1. the *member*'s pertinent medical records;
2. the covered person's health care provider's recommendation;

3. consulting reports from appropriate health care providers and other documents submitted by us or our designee *utilization review* organization, the *member*, the *member*'s *authorized representative*, or the covered person's treating provider;
4. the terms of coverage under the *member*'s health benefit plan with us to ensure that the independent review organization's decision is not contrary to the terms of coverage under the *member*'s health benefit plan with the health carrier, unless the terms are inconsistent with *applicable law*;
5. the most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
6. any applicable clinical review criteria developed and used by us or our designee *utilization review* organization;
7. the opinion of the independent review organization's clinical reviewer or reviewers after considering the above items to the extent the information or documents are available, and the clinical reviewer or reviewers considers the information or documents appropriate; and
8. in the case of *medically necessary* determinations for *substance use disorder*s, the patient placement criteria established by the American Society of Addiction Medicine.

Within 5 calendar days after the date of receipt of all necessary information, but in no event more than 45 calendar days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the Director, us, the *member*, and, if applicable, the *member*'s *authorized representative*. In reaching a decision, the assigned independent review organization is not bound by any claim determinations reached prior to the submission of information to the independent review organization. In such cases, the following provisions shall apply:

The independent review organization shall include in the notice:

1. a general description of the reason for the request for external review;
2. the date the independent review organization received the assignment from the Director to conduct the external review;
3. the time period during which the external review was conducted;
4. references to the evidence or documentation, including the evidence-based standards, considered in reaching its decision;
5. the date of its decision;
6. the principal reason or reasons for its decision, including what applicable, if any, evidence-based standards that were a basis for its decision; and
7. the rationale for its decision.

Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, we immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

Expedited External Review

A *member* or a *member*'s *authorized representative* may file a request for an expedited external review with the Director either orally or in writing:

1. immediately after the date of receipt of a notice of serious jeopardization of *member*'s ability to regain maximum function, prior to a final adverse determination;
2. immediately after the date of receipt of a notice of final adverse determination; or
3. if we fail to provide a decision on request for an *expedited appeal* within 48, except to the extent the *member* or *authorized representative* requested or agreed to a delay.

Upon receipt of a request for an expedited external review, the Director shall immediately send a copy of the request to us. Immediately upon receipt of the request for an expedited external review we shall determine whether the request meets the reviewability requirements. In such cases, the following provisions shall apply:

1. We shall immediately notify the Director, the *member*'s, and, if applicable, the *member*'s *authorized representative* of its eligibility determination.
2. The notice of initial determination shall include a statement informing the *member*'s and, if applicable, the *member*'s *authorized representative* that a health carrier's initial determination that an external review request is ineligible for review may be objected to the Director by filing a *complaint* with the Illinois Department of Insurance.
3. The Director may determine that a request is eligible for expedited external review notwithstanding our initial determination that the request is ineligible and require that it be referred for external review.
4. In making a determination, the Director's decision shall be made in accordance with the terms of the covered person's health benefit plan, unless such terms are inconsistent with *applicable law*, and shall be subject to all applicable provisions of this provision.
5. The Director may specify the form for our notice of initial determination and any supporting information to be included in the notice.

Upon receipt of the notice that the request meets the reviewability requirements, the Director shall immediately assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Director to conduct the expedited review. In such cases, the following provisions shall apply:

1. Assignment of an approved independent review organization to conduct an external review in accordance with this section shall be made from those approved independent review organizations qualified to conduct external review as required by Sections 50 and 55 of the Health Carrier External Review Act.

2. The Director shall immediately notify us of the name of the assigned independent review organization. Immediately upon receipt from the Director of the name of the independent review organization assigned to conduct the external review, but in no case more than 24 hours after receiving such notice, we or our designee *utilization review* organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.
3. If we or our *utilization review* organization fails to provide the documents and information within the specified timeframe, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.
4. Within one business day after making the decision to terminate the external review and make a decision to reverse the adverse determination or final adverse determination, the independent review organization shall notify the Director, us, the *member*, and, if applicable, the *member*'s *authorized representative* of its decision to reverse the adverse determination or final adverse determination.

In addition to the documents and information provided by us or our *utilization review* organization and any documents and information provided by the *member* and the *member*'s *authorized representative*, the independent review organization, to the extent the information or documents are available, and the independent review organization considers them appropriate, shall consider information in reaching a decision.

As expeditiously as the *member*'s medical condition or circumstances requires, but in no event more than 72 hours after the date of receipt of the request for an expedited external review by the independent review organization, the assigned independent review organization shall:

1. make a decision to uphold or reverse the final adverse determination; and
2. notify the Director, us, the *member*, the *member*'s health care provider, and, if applicable, the *member*'s *authorized representative*, of the decision.

In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during our *utilization review* process or the health carrier's internal *appeal* process.

Upon receipt of notice of a decision reversing the adverse determination or final adverse determination, we shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

If the notice provided was not in writing, then within 48 hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the Director, we, the *member*'s, and, if applicable, the *member*'s *authorized representative* including the information as applicable.

An expedited external review may not be provided for retrospective adverse or final adverse determinations.

The assignment by the Director of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those independent review organizations approved by the Director.

External Review of Experimental or Investigational Treatment Adverse Determinations

Within four months after the date of receipt of a notice of an adverse determination or final adverse determination that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is *experimental or investigational*, a *member* or the *member*'s *authorized representative* may file a request for an external review with the Director.

The following provisions apply to cases concerning expedited external reviews:

1. A *member* or the *member*'s *authorized representative* may make an oral request for an expedited external review of the adverse determination or final adverse determination if the covered person's treating *physician* certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.
2. Upon receipt of a request for an expedited external review, the Director shall immediately notify the health carrier.
3. The following provisions apply concerning notice:
    a. Upon notice of the request for an expedited external review, the health carrier shall immediately determine whether the request meets the reviewability requirements. We shall immediately notify the Director and the *member* and, if applicable, the *member*'s *authorized representative* of its eligibility determination.
    b. The Director may specify the form for our notice of initial determination and any supporting information to be included in the notice. The notice of initial determination under shall include a statement informing the *member* and, if applicable, the *member*'s *authorized representative* of our initial determination that the external review request is ineligible for review may be objected to the Director by filing a *complaint* with the Illinois Department of Insurance.
4. The following provisions apply concerning the Director's determination:
    a. The Director may determine that a request is eligible for external review notwithstanding our initial determination that the request is ineligible and require that it be referred for external review.
    b. In making a determination, the Director's decision shall be made in accordance with the terms of the *member*'s health benefit plan, unless such terms are inconsistent with *applicable law*.

5. Upon receipt of the notice that the expedited external review request meets the reviewability requirements, the Director shall immediately assign an independent review organization to review the expedited request from the list of approved independent review organizations compiled and maintained by the Director and notify us of the name of the assigned independent review organization.
6. At the time we receive the notice of the assigned independent review organization, we or our designee *utilization review* organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

Except for a request for an expedited external review, within one business day after the date of receipt of a request for external review, the Director shall send a copy of the request to us.

Within five business days following the date of receipt of the external review request, we shall complete a preliminary review of the request to determine whether:

1. the individual is or was a *member* in the health benefit plan at the time the health care service was recommended or requested or, in the case of a retrospective review, at the time the health care service was provided;
2. the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination is a *covered service* under the *member*'s health benefit plan except for the health carrier's determination that the service or treatment is *experimental or investigational* for a particular medical condition and is not explicitly listed as an excluded benefit under the *member*'s health benefit plan with us;
3. the *member*'s health care provider has certified that one of the following situations is applicable:
    a. standard health care services or treatments have not been effective in improving the condition of the *member*;
    b. standard health care services or treatments are not medically appropriate for the *member*'s; or
    c. there is no available standard health care service or treatment covered by us that is more beneficial than the recommended or requested health care service or treatment.
4. the *member*'s health care provider:
    a. has recommended a health care service or treatment that the *physician* certifies, in writing, is likely to be more beneficial to the *member*, in the *physician*'s opinion, than any available standard health care services or treatments; or
    b. who is a licensed, board certified or board eligible *physician* qualified to practice in the area of medicine appropriate to treat the *member*'s condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the *member* that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the *member* than any available standard health care services or treatments;

5. the *member* has exhausted our internal *appeal* process, unless the *member* is not required to exhaust the health carrier's internal *appeal*; and
6. the member has provided all the information and forms required to process an external review.

The following provisions apply concerning requests:

1. Within one business day after completion of the preliminary review, we shall notify the Director and *member* and, if applicable, the *member*'s *authorized representative* in writing whether the request is complete and eligible for external review.
2. If the request:
   a. is not complete, then we shall inform the Director and the *member* and, if applicable, the *member*'s *authorized representative* in writing and include in the notice what information or materials are required to make the request complete; or
   b. is not eligible for external review, then we shall inform the Director and the *member* and, if applicable, the *member*'s *authorized representative* in writing and include in the notice the reasons for its ineligibility.
3. The Department may specify the form for our notice of initial determination and any supporting information to be included in the notice.
4. The notice of initial determination of ineligibility shall include a statement informing the *member* and, if applicable, the *member*'s *authorized representative* that our initial determination that the external review request is ineligible for review may be objected to the Director by filing a *complaint* with the Illinois Department of Insurance.
5. Notwithstanding our initial determination that the request is ineligible for external review, the Director may determine that a request is eligible for external review and require that it be referred for external review.

Whenever a request for external review is determined eligible for external review, we shall notify the Director and the *member* and, if applicable, the *member*'s *authorized representative*.

Whenever the Director receives notice that a request is eligible for external review following the preliminary review conducted, within one business day after the date of receipt of the notice, the Director shall:

1. assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Director and notify us of the name of the assigned independent review organization; and
2. notify in writing the *member* and, if applicable, the *member*'s *authorized representative* of the request's eligibility and acceptance for external review and the name of the independent review organization.

The Director shall include in the notice provided to the *member* and, if applicable, the *member*'s *authorized representative* a statement that the *member* or the *member*'s *authorized representative* may, within five business days following the date of receipt of the notice provided, submit in writing to the assigned independent review organization additional information that the independent review organization shall consider when conducting the

external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five business days.

The following provisions apply concerning assignments and clinical reviews:

1. Within one business day after the receipt of the notice of assignment to conduct the external review, the assigned independent review organization shall select one or more clinical reviewers, as it determines is appropriate, to conduct the external review.
2. The provisions of this item apply concerning the selection of reviewers:
    a. In selecting clinical reviewers, the assigned independent review organization shall select *physician*s or other health care professionals who meet the minimum qualifications and, through clinical experience in the past three years, are experts in the treatment of the *member*'s condition and knowledgeable about the recommended or requested health care service or treatment.
    b. Neither we, the *member*, nor the *member*'s *authorized representative* will choose or control the choice of the *physician*s or other health care professionals to be selected to conduct the external review.

Each clinical reviewer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during our *utilization review* process or the health carrier's internal *appeal* process.

Within five business days after the date of receipt of the notice provided, we or our designee *utilization review* organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination; in such cases, the following provisions shall apply:

1. failure by us or our *utilization review* organization to provide the documents and information within the specified time frame shall not delay the conduct of the external review.
2. If we or our *utilization review* organization fails to provide the documents and information within the specified time frame, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.
3. Immediately upon making the decision to terminate the external review and make a decision to reverse the adverse determination or final adverse determination, the independent review organization shall notify the Director, us, the *member*, and, if applicable, the *member*'s *authorized representative* of its decision to reverse the adverse determination.

Upon receipt of the information from us or our *utilization review* organization, each clinical reviewer selected shall review all of the information and documents and any other information submitted in writing to the independent review organization by the *member* and the *member*'s *authorized representative*.

Upon receipt of any information submitted by the *member* or the *member*'s *authorized representative*, the independent review organization shall forward the information to us within one business day. In such cases, the following provisions shall apply:

1. Upon receipt of the information, if any, we may reconsider its adverse determination or final adverse determination that is the subject of the external review.
2. Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review.
3. The external review may be terminated only if we decide, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination. In such cases, the following provisions shall apply:
    a. Immediately upon making its decision to reverse its adverse determination or final adverse determination, we shall notify the Director, the *member* and, if applicable, the *member*'s *authorized representative*, and the assigned independent review organization in writing of its decision.
    b. Upon notice from the health carrier that we have made a decision to reverse its adverse determination or final adverse determination, the assigned independent review organization shall terminate the external review.

The following provisions apply concerning clinical review opinions:

1. Within 20 calendar days after being selected, each clinical reviewer shall provide an opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.
2. Each clinical reviewer's opinion shall be in writing and include the following information:
    a. a description of the *member*'s medical condition;
    b. a description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the *member* than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;
    c. a description and analysis of any medical or scientific evidence considered in reaching the opinion;
    d. a description and analysis of any evidence-based standard; and
    e. information on whether the reviewer's rationale for the opinion is based on 215 ILCS 180/42(m)(5).

The provisions concerning the timing of opinions related to expedited external review:

1. Each clinical reviewer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the *member*'s medical condition or circumstances requires, but in no event more than five calendar days after being selected.

2. If the opinion provided was not in writing, then within 48 hours following the date the opinion was provided, the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required.

In addition to the documents and information provided by us or our *utilization review* organization and the *member* and the *member*'s *authorized representative*, if any, each clinical reviewer selected, to the extent the information or documents are available and the clinical reviewer considers appropriate, shall consider the following in reaching a decision:

1. the *member*'s pertinent medical records;
2. the *member*'s health care provider's recommendation;
3. consulting reports from appropriate health care providers and other documents submitted by us or our designee *utilization review* organization, the *member*, the *member*'s *authorized representative*, or the *member*'s treating *physician* or health care professional;
4. the terms of coverage under the *member*'s health benefit plan with us to ensure that, but for our determination that the recommended or requested health care service or treatment that is the subject of the opinion is *experimental or investigational*, the reviewer's opinion is not contrary to the terms of coverage under the *member*'s health benefit plan with us and
5. whether the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition or medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the *member* than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

The following provisions apply concerning decisions, notices, and recommendations:

1. The provisions of this item apply concerning decisions and notices:
    a. Except as provided, within 20 calendar days after the date it receives the opinion of each clinical reviewer, the assigned independent review organization, shall make a decision and provide written notice of the decision to the Director, us, the *member*, and the *member*'s *authorized representative*, if applicable.
    b. For an expedited external review, within 48 hours after the date it receives the opinion of each clinical reviewer, the assigned independent review organization, shall make a decision and provide notice of the decision orally or in writing to the Director, us, the *member*, and the *member*'s *authorized representative*, if applicable. If such notice is not in writing, within 48 hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the Director, us, the *member*, and the *member*'s *authorized representative*, if applicable.

If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should be covered, then the independent review organization shall make a decision to reverse the health carrier's adverse determination or final adverse determination.

If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination or final adverse determination.

These provisions apply to cases in which the clinical reviewers are evenly split:

1. If the clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, then the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers.
2. The additional clinical reviewer selected shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions.
3. The selection of the additional clinical reviewer shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers.

The independent review organization shall include in the notice provided:

1. a general description of the reason for the request for external review;
2. the written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;
3. the date the independent review organization received the assignment from the Director to conduct the external review;
4. the time period during which the external review was conducted;
5. the date of its decision;
6. the principal reason or reasons for its decision; and
7. the rationale for its decision.

Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, we shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

The assignment by the Director of an approved independent review organization to conduct an external review shall be done on a random basis among those independent review organizations approved by the Director.

Binding Nature of External Review Decision

An external review decision is binding on us. An external review decision is binding on the covered person except to the extent the *member* has other remedies available under *applicable law*. A *member* or the *member*'s *authorized representative* may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the *member* has already received an external review.

If a *member* has a change in medical status for a treatment or procedure not previously approved, the *member* may become eligible for a subsequent external review.

Disclosure Requirements

We shall include a description of the external review procedures in, or attached to, the *contract*, and Outline of Coverage or other Evidence of Coverage it provides to *member*s.

The description required shall include a statement that informs the covered person of the right of the *member* to file a request for an external review of an adverse determination or final adverse determination with the Director. The statement shall explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness. The statement shall include the toll-free telephone number and address of the Office of Consumer Health Insurance within the Department of Insurance.

Appeals and Grievances Filing and Key Communication Timelines

	Timely Filing	Acknowledgment	Resolution	
Standard Grievance	N/A	3 business days	30 calendar days	30 calendar days
Grievance Committee	10 calendar days	3 business days	30 calendar days	30 calendar days
Standard Pre-Service Appeal	180 calendar days	3 business days	15 business days	15 calendar days
Expedited Pre-Service Appeal	180 calendar days	N/A	24 hours	N/A
Standard Post-Service Appeal	180 calendar days	3 business days	15 business days	15 calendar days
External Review	4 months	5 business days	45 calendar days	N/A
Expedited External review	4 months	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 intentional misrepresentation of fact made regarding a *member* during the application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:

1. The misrepresented fact is contained in a written application signed by a *member*;
2. A copy of the application 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, Intentional Misrepresentation or False Information

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

Conformity with Applicable Laws

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

Personal Health Information (PHI)

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

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

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

Language Assistance

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

Binding Arbitration

If attempts to negotiate reimbursement for services provided by a nonparticipating provider do not result in a resolution of the payment dispute within 30 days after receipt of written explanation of benefits by the health insurance issuer, then the health insurance issuer or nonparticipating provider or the facility may initiate binding arbitration to determine payment for services provided on a per-bill or batched-bill basis.

Binding arbitration shall provide for a written decision within 45 days after the request is filed with the Department of Insurance. Both parties shall be bound by the arbitrator's decision.