2026 EVIDENCE OF COVERAGE

AmbetterHealth.com/en/IN

Celtic Insurance Company

Ambetter Health

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

Individual Member Contract

In this *contract*, the terms "you," or "your" will refer to the *member* or any *dependent member* enrolled in this *contract*. The terms "we," "our," or "us" will refer to Celtic Insurance Company or Ambetter Health (Ambetter).

AGREEMENT AND CONSIDERATION

This document along with the corresponding *Schedule of Benefits* and your 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 the timely payment of premiums, we will provide 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 covered services.

In addition to the above, this guarantee for continuity of coverage shall not prevent us from cancelling or non-renewing this *contract* in the following events:

1. non-payment of premium;
2. a *member* fails to pay any *deductible* or *copayment amount* owed to us and not the provider of services;
3. a *member* is found to be in material breach of this *contract*; or
4. a change in federal or state law no longer permits the continued offering of such coverage, such as CMS guidance related to individuals who are Medicare eligible.

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

At least 31 calendar days' notice of any plan to take an action or make a change permitted by this clause will be delivered to you at your last address as shown in our records. We will make no change

in your premium solely because of claims made under this *contract* or a change in a *member's* health. While this *contract* is in force, we will not restrict coverage already in force. If we discontinue offering and decide not to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 90 calendar days prior to the date that we discontinue coverage.

RIGHT TO RETURN 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 and the *contract* will be considered null and void from the *effective date*.

This *contract* contains a *deductible* provision.

This *contract* contains *prior authorization* requirements. You may be required to obtain a referral from a *PCP* in order to receive care from a *specialist physician*. Benefits may be reduced or not covered if the requirements are not met. Please refer to the *Schedule of Benefits* and the **PRIOR AUTHORIZATION** section.

Celtic Insurance Company

Kevin J. Counihan, CEO

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INTRODUCTION

Welcome to Ambetter! 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*, the enrollment application as submitted to the Health Insurance Marketplace and any amendments or riders attached shall constitute the entire *contract* under which *covered services* and supplies are provided or paid for by us.

Because many of the provisions are interrelated, you should read this entire *contract* to gain a full understanding of your coverage. Many words used in this *contract* have special meanings when used in a health care setting: these words are italicized and are defined 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 see references to Celtic Insurance Company and Ambetter. Ambetter operates under its legal entity, Celtic Insurance Company and both may be referred to as the "plan."

How to Contact Us

Ambetter Health
429 North Pennsylvania Street
Suite 109
Indianapolis, IN 46204

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

Member Services:	1-877-687-1182
TTY line:	1-800-743-3333
Fax:	1-877-941-8072
Emergency:	911
Suicide and Crisis Lifeline	988 (call or text)
24/7 Nurse Advice Line:	1-855-604-1303

Interpreter Services

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

Our interpreter services are provided at no cost to you. We have medical interpreters to assist with languages other than English via phone. An interpreter will not go to a provider's office with you. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for oral interpretation or to request materials in Braille or large font.

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

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

You have the right to:

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

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

b. Health Care Power of Attorney; or

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

You have the responsibility to:

1. Read this entire *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* 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 provider. You may change your *PCP* verbally or in writing by contacting Member Services.
7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
8. Follow the treatment plans and instructions for care that you have agreed on with your health care professionals and *physician*.
9. Tell your health care professional and *physician* if you do not understand your treatment plan or what is expected of you. You should work with your *PCP* to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.
10. Follow all health benefit plan guidelines, provisions, policies, and procedures.
11. Use any emergency room only when you think you have a medical emergency. For all other care, you should call your *PCP*.
12. When you enroll in this coverage, give all information about any other medical coverage you have. If, at any time, you get other medical coverage besides this coverage, you must tell the entity with which you enrolled (either the Health Insurance Marketplace or us).
13. Pay your monthly premiums on time and pay all *deductible amounts*, *copayment amounts* or *coinsurance amount* on time.
14. Notify us or the entity you enrolled with of any enrollment related changes that would affect your *contract* within 60 calendar days of the event. Enrollment related changes include the following: birth of a child, adoption, marriage, divorce, change of address, adding/removing a dependent, *spouse*/domestic partner becomes eligible under a different insurer or incarceration where *member cost share* would need to transfer from one policy to another policy.
15. Verify the participating *network* status of your medical providers including providers that you are referred to by your *PCP* or other *network provider*.

NOTE: Notify the Health Insurance Marketplace or us for an off-exchange plan, if you have any changes to your name, address or family members covered under this *contract*. These changes can also be done by logging into your consumer dashboard on enroll.ambetterhealth.com.

IMPORTANT INFORMATION

Provider Directory

A listing of *network providers* is available online at AmbetterHealth.com/en/IN. We have plan *physicians*, *hospitals* and other *medical practitioners* who have agreed to provide you with your health care services. You may find any of our *network providers* by accessing the "Find a Doctor" page on our website and selecting the Ambetter *network*. There you will have the ability to narrow your search by provider specialty, zip code, gender, languages spoken and whether or not they are currently accepting new patients and languages spoken. 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 and qualifications.

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

If you receive services from a *non-network provider* because of inaccurate information in the Provider Directory or in response to an inquiry about *network* status, please contact Member Services. If the services you received are otherwise *covered services*, you will only be responsible for paying the *cost sharing* that applies to *network providers* and 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 to you after we receive your completed enrollment materials and you have paid your initial binder payment. This card is proof that you are enrolled in the Ambetter plan. You need to keep this card with you at all times. Please show this card every time you go for any service under the *contract*. A temporary *member* identification card can be downloaded from AmbetterHealth.com/en/IN.

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

Website

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

1. Finding a *network provider*, including *hospitals* and pharmacies.

2. Our programs and services, including programs to help you get and stay healthy.
3. A secure portal for you to check the status of your claims, make payments and obtain a copy of your *member* identification card.
4. *Member* Rights and Responsibilities.
5. Notice of Privacy Practices.
6. Current events and news.
7. Our formulary or *prescription drug* list.
8. *Deductible* and *copayment* accumulators.
9. Selecting a *primary care physician*.
10. Health Risk Assessment form, “Welcome Survey.”

Quality Improvement

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

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

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

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

Protection from Balance Billing

Under federal law, effective January 1, 2022, *non-network providers* or facilities are prohibited from *balance billing* health plan *members* for services that are subject to *balance billing protections* as described in the **DEFINITIONS** section of this *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*.

DEFINITIONS

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

Wherever used in this *contract*:

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

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

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

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

1. A denial of a request for service.
2. A denial, reduction, or failure to provide or make payment in whole or in part for a *covered service*.
3. A determination that an admission, continued stay or other health care service does not meet our requirements for medical necessity, appropriateness, health care setting or level of care or effectiveness.
4. A determination that a service is *experimental or investigational*, *cosmetic treatment*, not *medically necessary* or inappropriate.
5. A denial of coverage based upon an eligibility determination.
6. A determination that *balance billing protections* do not apply to a service.
7. An incorrectly calculated amount of *cost sharing* a *member* owes when *balance billing protections* apply.
8. A *rescission* of coverage determination as described in the **GENERAL PROVISIONS** section of this *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 **APPEAL AND GRIEVANCE PROCEDURES** section of this *contract* for information on your right to *appeal* an *adverse benefit determination*.

Allowed amount (also see ***Eligible expense***) means the maximum amount we will pay a provider for a *covered service*. When a *covered service* is received from a *network provider*, the *allowed amount*

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

NOTE: If you receive services from a *non-network provider*, you may be responsible for the difference between what we agreed to pay and the full *billed amount* for a service. This is known as *balance billing*. This amount is likely more than *network* costs for the same service and might not count toward your annual *maximum out-of-pocket amount* limit. However, you will not be *balance billed* when *balance billing protections* apply to *covered services*. However, you will not be responsible for *balance billing* for non-network care that is subject to *balance billing protections* and otherwise covered under your *contract*. See ***Balance billing***, ***Balance billing protections*** and ***Non-network provider*** definitions for additional information. If you are, *balance billed* in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.

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

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

Appeal means a *grievance* requesting the insurer to reconsider, reverse or otherwise modify an *adverse benefit determination*.

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

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

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

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

1. A person to whom a covered individual has given express, written consent to represent that individual in an internal *appeals* process or external review process of an *adverse benefit determination*;
2. A person authorized by law to provide substituted consent for a covered individual and communicate with the health plan on other issues; 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 providers* may not balance bill you for *covered services* beyond your applicable *cost sharing* amounts.

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

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

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

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

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

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

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

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 at the sole option of us, 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. Has agreed with us or an entity designated by us to meet quality of care criteria on a cost-efficient basis. The fact that a *hospital* is a *network provider* does not mean it is a *Center of Excellence*.

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

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

Complications of pregnancy means:

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

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

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

Contract means this *contract* as issued and delivered to you. It includes the attached pages, the enrollment application, and any amendments and/or riders.

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

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

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

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

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

1. 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 a sickness or bodily *injury*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. For *network providers*: When a *covered service* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.
2. For *non-network providers*, unless otherwise required by Federal or Indiana law, the *eligible expense* is as follows:
    a. When *balance billing protections* apply to a *covered service* received from a *non-network provider*, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full. If the provider has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by *applicable law*, the *eligible expense* is reimbursement as determined by us and as required by *applicable law*.
    b. When a *covered service* is received from a non-network professional provider who renders non-emergency services, at a *network* facility, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full. If the provider has not agreed to accept a negotiated fee with us as payment in full, unless otherwise required by *applicable law*, the *eligible expense* is reimbursement as determined by us and as required by *applicable law*. Unless you receive and sign the necessary written *notice and consent* document under federal law before the services are provided, you should not be *balanced billed* for the difference between the amount we pay and the provider's charges, but you may be subject to *cost sharing* obligations. *Member cost share* will be calculated from the recognized amount based upon *applicable law*. If you are *balanced billed* in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.
    c. For all other *covered services* received from a *non-network provider* for which any needed *authorization* is received by us, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full (you will not be billed for the difference between the negotiated fee and the provider's charge). If there is no negotiated fee agreed to by the provider with us, the *eligible expense* is reimbursement as determined by us and as required by *applicable law*. In addition to applicable *cost sharing*, you may be *balance billed* for these services.

Emergency condition means a medical condition or a *behavioral health* condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who

possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

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

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

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

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

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

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (FDA) regulation, regardless of whether the trial is subject to USFDA oversight.
2. An *unproven service*.
3. Subject to FDA approval and:
    a. It does not have FDA approval;
    b. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has FDA approval but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of an FDA-approved drug is a use that is determined by us to be:

i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;

ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or

iii. Not an *unproven service*; or

d. It has FDA approval but is being used for a use or to treat a condition, that is not listed on the Premarket Approval issued by the FDA or has not been determined through peer reviewed medical literature to treat the medical condition of the *member*.

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

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

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

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

If no credible scientific evidence is available, then standards 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 by us.

Generic prescription drug means a drug that has same active ingredient as brand name drug. Food and Drug Administration (FDA) rates *generic prescription drugs* as equivalent to brand name drugs in safety and efficacy. This tier may cover select over-the-counter (OTC's) and branded drug products.

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

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.

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

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

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

2. Prescribed and supervised by a *physician*.

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

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

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

Hospice means services designed for and provided to *members* who are diagnosed with a terminal condition and are in a *hospice inpatient* program or in a home setting, as certified by a *network physician*. We work with certified *hospice care programs* licensed by the state to minimize patient discomfort and address the special physical, psychological and social needs of *terminally ill members* and their *immediate family*.

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

Hospital means an institution that:

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

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

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

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

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

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

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

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 days per week.

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

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

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

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

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

Medically necessary means those *covered services*, items, or supplies that:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Demonstrate that the *member* is reasonably capable of improving in his/her functional ability;
5. Is not solely for the convenience of the *physician* or the *member*;
6. Is not *experimental or investigational*;
7. Is provided in the most cost-effective care facility or setting;
8. 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

9. When specifically applied to a *hospital* confinement, it means that the diagnosis and treatment of your medical symptoms or conditions cannot be safely provided as an outpatient.

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

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

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

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

Necessary medical supplies mean medical supplies that are:

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

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

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

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

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

Non-elective cesarean section means:

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

Non-network provider means a *medical practitioner*, provider, facility, or other provider who is NOT a *network provider*. Services received from a *non-network provider* are not covered, except as specifically stated in this *contract*:

1. *Emergency services*, as described in the **MAJOR MEDICAL EXPENSE BENEFITS** section of this *contract*;

2. Non-emergency health care services received at a *network* facility, as described in the **ACCESS TO CARE** section of this *contract*; or
3. Air ambulance services; and
4. Situations otherwise specifically described in this *contract*.

Non-preferred prescription drug means a drug that currently may or may not have a generic equivalent, branded drug that is therapeutically equivalent to another branded drug and that we deemed non-preferred or generic product that is therapeutically equivalent to another generic product and we deemed non-preferred.

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

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

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

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

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

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

Physician means a licensed *medical practitioner* who is practicing within the scope of his or her licensed authority in treating a bodily *illness* or *injury* and is required to be covered by *applicable 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-stabilization services mean services furnished after a *member's emergency condition* is *stabilized* and as part of outpatient observation or *inpatient* or *outpatient services* with respect to the visit in which other *emergency services* are furnished.

Preceding prescription drug means as a condition of coverage for succeeding treatment with another *prescription drug*, means a *prescription drug* that, according to a step therapy protocol, must be first used to treat an insured's condition and determined to be inappropriate.

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

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

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

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

Primary care physician or ***PCP*** means a *physician* who gives or directs health care services for you and is in charge of your ongoing care. *PCPs* include family practitioners, general practitioners, internists, advanced practice registered nurses (APRN), physician assistants (PA), obstetricians/gynecologists (ob-gyns) and pediatricians or any other practice allowed by us.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Spouse means the person to whom you are lawfully married.

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

Standard grievance means any *grievance* not related to an *adverse benefit determination*.

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 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 a gestational carrier who, as part of a *surrogacy arrangement*;

1. uses her own egg that is fertilized by a donor; or
2. has a fertilized egg placed in her body but the egg is not her own.

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

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

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

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

Tobacco or nicotine use or ***use of tobacco or nicotine*** means *use of tobacco or nicotine* by individuals who may use nicotine or tobacco on average four or more times per week and within no longer than the six months immediately preceding the date application for this *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.

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

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

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

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

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

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

DEPENDENT MEMBER COVERAGE

Dependent Member Eligibility

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

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

Effective Date for Initial Dependent Members

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

Coverage for a Newborn Child

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

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

Coverage for an Adopted Child

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

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

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

1. Notification of the addition of the child from the Health Insurance Marketplace within 60 calendar days of the birth or placement and
2. any additional premium required for the addition of the child within 90 calendar days of the date of placement.

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

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

Adding Other Dependent Members

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

ELIGIBILITY AND ENROLLMENT

For All Members

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

1. The date we decline to renew this *contract*, as stated in the **Discontinuance** provision under the **TERMINATION** section;
2. The *subscriber* residing outside the *service area* or moving permanently outside the *service area* of this plan;
3. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact;
4. The date of a *member's* death;
5. 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
6. The date of termination that the Health Insurance Marketplace provides us upon your request of cancellation to the Health Insurance Marketplace or if you enrolled directly with us, the last calendar 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 calendar 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 such as marriage, death, or other change in family status) or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Marketplace) at www.healthcare.gov or 1-800-318-2596. If you enrolled through Ambetter, you can contact Member Services.

For Dependent Members

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

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 disability or physical disability that began before the age limit was reached; and
2. Mainly dependent on you for support.

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

Open Enrollment

There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 1, 2025, and extends through January 15, 2026. *Qualified*

individuals who enroll on or before December 15, 2025, will have an *effective date* of coverage on January 1, 2026.

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

1. The *qualified individual* has not been determined eligible for *advance premium tax credits* or *cost sharing reductions*; or
2. The *qualified individual* pays the entire premium for the first partial month of coverage as well as all *cost sharing*, thereby waiving the benefit of *advance premium tax 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 the first of September and no later than the 30th of September.

Special Enrollment Periods

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

Qualifying events include:

1. A *qualified individual* or *dependent member* experiences a *loss* of *minimum essential coverage*, non-calendar year group or individual health insurance coverage, pregnancy-related coverage, access to health care services through coverage provided to a pregnant *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 one or more calendar days during the 60 calendar days preceding the date of marriage;
3. A *qualified individual* or dependent, who was not previously a citizen, national or lawfully present individual gains such status; or who is no longer incarcerated or whose incarceration is pending the disposition of charges;
4. A *qualified individual's* enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation or inaction of an officer, employee or its instrumentalities as evaluated and are determined by the Health Insurance Marketplace;
5. A *member* or dependent adequately demonstrates to the Health Insurance Marketplace that the plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the *member*;
6. A *qualified individual*, *member* or dependent, adequately demonstrates to the Health Insurance Marketplace that a material error related to plan benefits, *service area* or premium influenced the *qualified individual's* or *member's* decision to purchase the *QHP*;
7. A *qualified individual* who was previously ineligible for advance payments of the premium tax credit solely because of a household income below 100 percent of the FPL and who, during the same timeframe, was ineligible for Medicaid because he or she was living in a non-

Medicaid expansion state, who either experiences a change in household income or moves to a different state resulting in the *qualified individual* becoming newly eligible for advance payments of the premium tax credit;

8. At the option of the Exchange, the *qualified individual*, or his or her dependent:
   a. Experiences a decrease in household income;
   b. Is newly determined eligible by the Exchange for advance payments of the premium tax credit; and
   c. Had *minimum essential coverage* as described in 26 CFR 1.5000A-1(b) for one or more days during the 60 calendar days preceding the date of the financial change.
9. 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*;
10. A *qualified individual* or dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for *advance premium tax credits* based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-2(c)(3);
11. A *qualified individual*, *member*, or dependent gains access to new *QHPs* as a result of a permanent move and had *minimum essential coverage* as described in 26 CFR 1.5000A–1(b) for one or more calendar days during the 60 calendar days preceding the date of the permanent move;
12. 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;
13. A *qualified individual* or *member* demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by Health and Human Services (HHS), that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide;
14. 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;
15. 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;
16. 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);
17. At the option of the Health Insurance Marketplace, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a plan through the Health Insurance Marketplace following termination of enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national or lawful presence;

18. A *qualified individual* or dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums or for which a government entity is providing subsidies and the employer completely ceases its contributions or government subsidies completely cease; or
19. A *qualified individual* or *member*, or their *dependent member*, who is eligible for advance payments of the premium tax credit and whose household income is expected to be no greater than 150 percent of the federal poverty level.

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

If you are currently enrolled in Ambetter Health, 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 calendar 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;

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

If a *qualified individual*, *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 calendar day of the triggering event the Health Insurance Marketplace must ensure that the coverage *effective date* is the first calendar 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 calendar 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 calendar day of the triggering event, coverage is effective on the first calendar day of the month following the date of the triggering event or, if the triggering event is on the first calendar day of a month, on the date of the triggering event. If the plan selection is made on or after the calendar day of the triggering event, coverage is effective on the first calendar 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, the Health Insurance Marketplace 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, the Health Insurance Marketplace must provide the earliest effective that would have been available, based on the applicable qualifying event.

Prior Coverage

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

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

PREMIUMS

Premium Payment

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

Grace Period

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 calendar day of the first month during the grace period if *advance premium tax credits* are received.

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

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

Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first calendar day of each month for coverage effective during such month. A grace period of 60 calendar days will be granted for the payment of each premium falling due after the first premium, during which grace period the *contract* shall continue in force. 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 HHS, as necessary, of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the grace period.

Third-Party Payment of Premiums or Cost Sharing

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

1. Ryan White HIV/AIDS Program under Title XXVI of the Public Health Services 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. An employer for an employee under an Individual Coverage Health Reimbursement Account (ICHRA) or Qualified Small Employer Health Reimbursement Account (QSEHRA) plan; or
7. Private, not-for-profit foundations which have no incentive for financial gain, no financial relationship or affiliation with providers of *covered services* and supplies on behalf of *members*, where eligibility is determined based on defined criteria without regard to health status and where payments are made in advance for a coverage period from the *effective date* of eligibility through the remainder of the calendar year.

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

Misstatement of Age

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

Change or Misstatement of Residence

If you change your *residence*, you must notify the Health Insurance Marketplace or log into your Online Member Account to process your change via Ambetter's *enhanced direct enrollment* tool, of your new *residence* within 60 calendar days of the change. As a result, your premium may change, and you may be eligible for a special enrollment period. See the **Special Enrollment Periods** provision under the **ELIGIBILITY AND ENROLLMENT** section for more information.

Misstatement of Tobacco or Nicotine Use

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

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

Ambetter may review your service selections and at our option we may offer rebate(s) when we determine higher quality and lower costs, evidence-based selection(s) were actively chosen by you.

Deductible

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

Copayments

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

Maximum Out-of-Pocket

You must pay any applicable *copayments*, *coinsurance*, or *deductible amounts* required until you reach the *maximum out-of-pocket amount* shown in your *Schedule of Benefits*. After the *maximum out-of-pocket amount* is met for an individual, we will pay 100 percent of the *allowed amount* for

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

The amount provided or payable will be subject to:

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

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

Non-Network Liability and Balance Billing

If you receive services from a *non-network provider*, you may have to pay more for services you receive. *Non-network providers* may be permitted to bill you for the difference between what we agreed to pay, and the full amount charged 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*.

Health Savings Account (HSA)

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

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

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

This Evidence of Coverage is administered by Ambetter and underwritten by Celtic Insurance Company. Neither entity is an HSA trustee, HSA custodian or a designated administrator for HSAs. Celtic Insurance Company, its designee, and its affiliates, including Ambetter, do not contribute to the HSA or provide tax, investment, or legal advice to *members*.

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

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

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

ACCESS TO CARE

Primary Care Physician (PCP)

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

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

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

You may not change your selection more frequently than once each month. If you do not select a *network PCP* for each *member*, one will be assigned. You may obtain a list of *network PCPs* at our website and accessing the “Find a Doctor” page or by calling Member Services.

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 *specialist physicians*
7. Provide any ongoing care you need
8. Update your medical record, which includes keeping track of all the care that you get from all of your providers
9. Treat all patients the same way with dignity and respect
10. Make sure you can contact him/her or another provider at all times
11. Discuss what advance directive are and file directives appropriately in your medical record.

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

Contacting Your Primary Care Physician (PCP)

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

If you need to cancel or change your appointment, call 24 hours in advance. At every appointment, make sure you bring your *member* identification card and a photo identification. Should you need care outside of your *PCP's* office hours, you should call your *PCP's* office for information on receiving after hours care in your area. If you have an urgent medical problem or question or cannot reach your *PCP* during normal office hours, call our 24/7 Nurse Advice Line at 1-855-604-1303 (TTY 1-800-743-3333). A licensed nurse is always available and ready to answer your health questions. If you are experiencing an *emergency condition*, call 911 or for a *behavioral health emergency condition,* call 988 or go to the nearest emergency room.

Changing Your Primary Care Physician (PCP)

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

Network Availability

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

Coverage Under Other Contract Provisions

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

Non-Emergency Services Outside of the Service Area

If you are traveling outside of the Indiana *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 Indiana 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. Be sure to a call us and report your emergency within one business day. You do not need *prior authorization* for *emergency services*.

Hospital Based Providers

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

Continuity of Care

Under the federal No Surprises Act, if a *member* is a *continuing care patient* with respect to a *network provider* and the contractual relationship with the provider is terminated, such that the provider is no longer in-network; or benefits are terminated because of a change in the terms of the participation of the provider, as it pertains to the service 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 calendar days after the notice provided in (1) is provided; or the
    b. The date on which such *member* is no longer a *continuing care patient* with respect to the provider.

New Technology

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

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

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

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

Preferred Partnerships

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

MAJOR MEDICAL EXPENSE BENEFITS

The plan provides coverage for health care services for a *member* or covered *dependent member*. Some services require *prior authorization*. *Copayment 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 *applicable law* and refer to benefits in at least the following categories: ambulatory patient services, *emergency services*, hospitalization, maternity and newborn care, mental health and *substance use disorder* services, including *behavioral health* treatment, *prescription drugs*, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. Essential health benefits provided within this *contract* are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime or annual dollar maximum.

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 will not pay benefits for any of the services, treatments, items, or supplies that exceed benefit limits.

Acquired Brain Injury Services

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

1. Cognitive *rehabilitation therapy*;
2. Neurocognitive therapy and *rehabilitation*;
3. Neurobehavioral, neuropsychological, neurophysiological, and psychophysiological testing and treatment;
4. Neurofeedback therapy; and
5. Remediation required for and related to treatment of an *acquired brain injury*.
6. 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 an approved facility where *covered services* are provided.

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

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

1. Has incurred an *acquired brain injury*;
2. Has been unresponsive to treatment;

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

Ambulance Services

Air Ambulance Service Benefits

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

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

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

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

Limitations: Benefits for air ambulance services are limited to:

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

Exclusions:

No benefits will be paid for:

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

5. Non-emergency air transportation, (for example, commercial flights).

Ground and Water Ambulance Service Benefits

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

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

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

NOTE: You should not be *balance billed* for covered ground or water ambulance services.

Exclusions:

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

Autism Spectrum Disorder Benefits

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

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

No limitation exists within the benefits for *applied behavior analysis* services. These services are subject to *prior authorization* to determine medical necessity. If multiple services are provided on the

same day by different providers, a separate *copayment amount* and/or *coinsurance amount* will apply to each provider.

Care Management Programs

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

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

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

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

Clinical Trial Coverage

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

Coverage will include routine patient care costs incurred for:

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

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

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

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

1. One of the National Institutes of Health (NIH);

2. The Centers for Disease Control and Prevention;
3. The Agency for Health Care Research and Quality;
4. The Centers for Medicare and Medicaid Services;
5. An NIH Cooperative Group or Center;
6. The FDA in the form of an investigational new drug application;
7. The federal Departments of Veterans' Affairs, Defense or Energy;
8. An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects; or
9. A qualified non-governmental research entity that meets the criteria for NIH Center support grant eligibility.

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

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

Colorectal Cancer Examinations and Laboratory Tests

Covered services include colorectal cancer tests for any non-symptomatic *member*, in accordance with the current United States Preventive Services Task Force (USPSTF) guidelines. *Covered services* include tests for *members* who are at least 45 years of age; or less than 45 years of age and at high risk.

Benefits for *covered services* for preventive care expenses and chronic disease management benefits may include the use of reasonable medical management techniques authorized by federal law to promote the use of high value preventive services from *network providers*. Reasonable medical management techniques may result in the application of *deductible amounts*, *coinsurance amount* or *copayment amounts* to services when a *member* chooses not to use a high value service that is otherwise exempt from *deductible amounts*, *coinsurance amount* provisions and *copayment amounts* provision, when received from a *network provider*.

Diabetic Care

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

Covered services include, but are not limited to:

1. Examinations including podiatric examinations;
2. Routine foot care such as trimming of nails and corns;
3. Laboratory and radiological diagnostic testing;
4. Self-management equipment and supplies such as urine and/or ketone strips, and blood glucose monitor supplies (glucose strips) for the device and syringes or needles;

5. Orthotics and diabetic shoes;
6. Urinary protein/microalbumin and lipid profiles;
7. Educational health and nutritional counseling for self-management, eye examinations; and prescription medication and retinopathy examination screenings, as *medically necessary*.

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

Dialysis Services

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

Covered services include:

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

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 amount for a standard item that is a *covered service*, serves the same purpose and is *medically necessary*. Any expense that exceeds the maximum amount for the standard item which is a *covered service* is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition. Repair, adjustment, and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

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

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

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

Benefits for repairs and replacement do not include the following:

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

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

Disposable Medical Supplies

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

Durable Medical Equipment

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 intravenous (I.V.) fluids and medicine;
5. Glucometer;
6. Tracheotomy tube;
7. Neonatal and sleep apnea monitors;
8. Cardiac monitors and wearable cardioverter defibrillators;
9. Augmentative communication devices are covered when we approve based on the *member's*

condition;

10. *Medically necessary* corrective footwear;
11. Rental of *medically necessary durable medical equipment* including: a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion and a ventilator;
12. Rental of one Continuous Passive Motion (CPM) machine per *member* following a covered joint *surgery;*
13. One pair of foot orthotics per year per *member*.

All types of *durable medical equipment* and supplies are subject to *prior authorization* as outlined by 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. Trans lift chairs.
6. Treadmill exerciser.
7. Tub chair used in shower.

Medical and Surgical Supplies

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

Covered services may include, but are not limited to:

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

Exclusions:

Non-covered services include but are not limited to:

1. Adhesive tape, band aids, cotton tipped applicators.
2. Arch supports.
3. Doughnut cushions.
4. Hot packs, ice bags.
5. Vitamins (except as provided for under the **Preventive Care se Benefits** provision).
6. Med-injectors.

7. Items usually stocked in the home for general use like band-aids, thermometers, and petroleum jelly.

Orthotic Devices

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

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

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

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

Exclusions:

Non-covered services include but are not limited to:

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

Prosthetics

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

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

Prosthetic devices should be purchased not rented and must be *medically necessary*. Applicable

taxes, shipping and handling are also covered.

Covered services may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates and vitallium heads for joint reconstruction.
2. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Custom fabricated breast prosthesis whether internal or external, following a mastectomy and one additional breast prosthesis per breast affected by the mastectomy. In addition, four surgical bras per benefit period are allowed, as required by the Women's Health and Cancer Rights Act. Maximums for *prosthetic devices*, if any, do not apply.
4. Artificial eyes or larynx, breast prosthesis, or basic artificial limbs. If more than one *prosthetic device* can meet a *member's* functional needs, only the charge for the most cost-effective *prosthetic device* will be considered a *covered service*.
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. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (not to exceed one per calendar year) when purchased through a *network provider*.
10. Cochlear implant.

Exclusions:

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

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

Family Planning and Contraception

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

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

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

Fertility Preservation

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

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

Habilitation, Rehabilitation and Extended Care Facility Benefits

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

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

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

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

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

Home Health Care Service Benefits

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

1. *Home health aide services* included as part of a skilled care services program.
2. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to your *Schedule of Benefits* for any limits associated with this benefit.
3. Professional fees of a licensed respiratory, physical, occupational or speech therapist required for *home health care*.
4. Intravenous (I.V.) medication and pain medication.
5. Hemodialysis and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental of *medically necessary durable medical equipment* at the discretion of the plan.

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

Limitations:

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

Exclusion:

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

Hospice Care Service Benefits

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

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

Benefits for *hospice inpatient*, home and outpatient care are available for a *member's* lifetime.

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

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

Exclusions and Limitations:

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

1. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice care program*; or

2. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision.

Hospital Benefits

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

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

Emergency Services

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

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

Long Term Acute Care Hospital (LTACH)

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

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

1. Complex wound care:
    a. Daily *physician* monitoring of wound
    b. Wound requiring frequent complicated dressing changes and possible repeated debridement of necrotic tissue
    c. Large wound with possible delayed closure, draining and/or tunneling or high output fistulas
    d. Lower extremity wound with severe ischemia
    e. Skin flaps and grafts requiring frequent monitoring
2. Infectious disease:
    a. Parenteral anti-infective agent(s) with adjustments in dose
    b. Intensive sepsis management

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

3. Medical complexity:
   a. Primary condition and at least two other actively treated co-morbid conditions that require monitoring and treatment
   b. Common conditions include metabolic disorders, stroke, heart failure, renal insufficiency, necrotizing pancreatitis, emphysema (COPD), peripheral vascular disease and malignant/end-stage disease
4. Rehabilitation:
   a. Care needs cannot be met in a *rehabilitation* or *skilled nursing facility*
   b. Patient has a comorbidity requiring acute care
   c. Patient is able to participate in a goal-oriented *rehabilitation* plan of care
   d. Common conditions include CNS conditions with functional limitations, debilitation, amputation, cardiac disease orthopedic *surgery*
5. Mechanical ventilator support:
   a. Failed weaning attempts at an acute care facility
   b. Patient has received mechanical ventilation for 21 consecutive days for six hours or more per day
   c. Ventilator management required at least every four hours as well as appropriate diagnostic services and assessments
   d. Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions
   e. Patient is hemodynamically stable and not dependent on vasopressors
   f. Respiratory status is stable with maximum PEEP requirement 10 cm H2O and FiO2 60 percent or less with O2 saturation at least 90 percent
   g. Common conditions include complications of acute lung *injury*, disorders of the central nervous and neuromuscular systems and cardiovascular, respiratory, and pleural/chest wall disorders
   h. Patient continues to meet the criteria above and does not meet the criteria to be transitioned to alternate level of care.

Infertility Services

Covered services under this benefit are limited to *medically necessary* diagnostic tests to determine *infertility* and treatment of the underlying medical conditions that may cause *infertility* (e.g., endometriosis, obstructed fallopian tubes and hormone deficiency).

Exclusions: No benefits will be payable for charges related to artificial insemination, in vitro (IVF), embryo transplant, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT).

Lymphedema Benefit

Treatment of lymphedema is covered when rendered or prescribed by a licensed *physician* or received in a *hospital* or other public or private facility authorized to provide lymphedema treatment.

Coverage includes multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

Mammography

Covered services for a *member* will include mammography screenings that align with USPSTF A and B rated guidelines, as well as *applicable laws*. This coverage includes *medically necessary* preventive and diagnostic mammograms, digital breast tomosynthesis, magnetic resonance imaging (MRI), ultrasound examinations and pathology evaluations. Coverage is available to all *members*, regardless of age, when these services are prescribed by a licensed *medical practitioner* working within the scope of their license. For further details on this benefit, please refer to the Preventive Care Guide..

Maternity Care

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 an *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require notification to us. We do not require that a *physician* or other health care provider obtain *prior authorization* for delivery.

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

1. Outpatient and *inpatient* pre- and post-partum care including examinations, prenatal diagnosis of genetic disorder, such as Adrenoleukodystrophy (ALD), laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment and childbirth classes.
2. *Physician* home visits and office services.
3. Parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
4. *Complications of pregnancy*.
5. *Hospital* stays for other *medically necessary* reasons associated with maternity care.
6. Pediatric care such as Pediatric Autoimmune Neuropsychiatric Disorders associated with streptococcal infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric syndrome (PANS);The PANDAS and PANS may not be subject to annual or lifetime limitation, *deductible*, *copayment*, or *coinsurance amount* provisions that are more restrictive than the annual or lifetime limitation, *deductible*, *copayment*, or *coinsurance amount* provisions that apply generally under the contract of accident and sickness insurance.

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 exists.

Duty to Cooperate

We do not cover services or supplies related to a *member's pregnancy* when a *member* is acting as a *surrogate* and has entered into a *surrogacy arrangement*. For more information on excluded services, please see the **GENERAL NON-COVERED SERVICES AND EXCLUSIONS** section. *Members* who are a *surrogate* at the time of enrollment or *members* who agree to a *surrogacy arrangement* during the plan year must, within 30 calendar days of enrollment or agreement to participate in a *surrogacy arrangement*, send us written notice of the *surrogacy arrangement* to Ambetter Health, Attn: Member Services, 429 North Pennsylvania Street Suite 109, Indianapolis, IN 46204. 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 immediately after birth. Each type of *covered service* incurred by the newborn child will be subject to his/her own *cost sharing* (*copayment amount*, *coinsurance amount*, *deductible amount* and *maximum out-of-pocket amount*), as listed in the *Schedule of Benefits*. Please refer to the **DEPENDENT MEMBER COVERAGE** section of this document for details regarding Coverage for a Newborn Child/Coverage for an Adopted Child.

Newborns' and Mothers' Health Protection Act Statement of Rights

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

Medical and Surgical Expense Benefits

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

1. For *surgery* in a *physician's* office, an *inpatient* facility, an outpatient facility, or a surgical facility, including services and supplies.
2. For pre-surgical and post-surgical procedures and testing, including but not limited to, diagnostic services using radiological, ultrasonographic or laboratory services.
    a. Laboratory tests or radiological examinations done on an outpatient basis in a *hospital* or other facility accepted by the *hospital* before *hospital* confinement or outpatient *surgery* or procedures. The tests must be for the same bodily *illness* or *injury* causing the *member* to be hospitalized or to have the outpatient *surgery* or procedure.
    b. Bone density studies
    c. Clinical laboratory tests
    d. Gastrointestinal laboratory procedures

e. Pulmonary function tests

f. Genetic testing

g. For *medically necessary* genetic or molecular cancer testing, including but not limited to, tumor mutation testing, next generation sequencing, hereditary germline mutation testing, pharmacogenomics testing, whole exome, and genome sequencing.

h. Biomarker testing:

i. Labeled indications for a test approved or cleared by the United States Food and Drug Administration;

ii. Indicated tests for a drug approved by the United States Food and Drug Administration;

iii. A warning or precaution on the label of a drug approved by the United States Food and Drug Administration;

iv. A national coverage determination of the Centers for Medicare and Medicaid Services (CMS);

v. A local coverage determination of a Medicare administrative contractor; or

vi. Nationally recognized clinical practice guidelines or consensus statements.

3. For medical services in an office or facility that is provided by a licensed *medical practitioner* or *specialist physician*, including consultations and *surgery* related services.

4. For chemotherapy (including oral chemotherapy), inhalation therapy, infusion therapy, and radiation therapy or treatment in a *hospital* or office setting.

5. For *durable medical equipment*, *prosthetic devices*, *orthotic devices*, or other *necessary medical supplies* following a medical or *surgical procedure* such as crutches, orthopedic splints, braces, or casts. Please see the **Durable Medical Equipment** provision of this *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, chest wall reconstruction, including aesthetic flat closure (as defined by the National Cancer Institute) and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedema.

b. *reconstructive surgery* for craniofacial abnormalities.

9. For *medically necessary* dental *surgery* due to:

a. An accidental *injury* which results in damage to natural teeth. *Injury* to the natural teeth will not include any *injury* as a result of chewing.

b. *Surgery* to correct a functional defect which results from a congenital and/or acquired disease or anomaly.

c. Cleft lip and cleft palate for an eligible *member*. *Covered services* include medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the treating *physician* or surgeon and such *physician* or surgeon certifies that such services are *medically necessary* and consequent to treatment of the cleft lip or cleft palate.

d. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* charges for dental care, rendered by a dentist, provided to the following *members*:

   i. A *member* whose treating *medical practitioner* in consultation with the dentist, determines the *member* has a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or

   ii. A *member* who has one or more medical conditions that would create significant or undue medical risk for the *member* during delivery of any dental treatment or *surgery* if not rendered in a *hospital* or *ambulatory surgical facility*.

   iii. Necessary dental treatment is that which, if left untreated, is likely to result in a medical condition. Use of general anesthesia in a *hospital* or *ambulatory surgical facility* is subject to *prior authorization*. Please call Member Services to confirm your benefits for the use of general anesthesia in a *hospital* or *ambulatory surgical facility*.

10. For *infertility* counseling and planning services when provided by a *network provider* and testing to diagnose *infertility*.

11. For the treatment of breast cancer by dose-intensive chemotherapy bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy bone marrow transplants or stem cell transplants.

12. For routine patient care for *members* enrolled in an eligible cancer clinical trial that is deemed an *experimental or investigational* treatment if the services provided are otherwise considered *covered services* under this *contract*. See the Clinical Trial Coverage provision of this *contract*.

13. For the following types of *medically necessary* implants and tissue grafts:

    a. Corneal transplants

    b. Artery or vein grafts

    c. Heart valve grafts

    d. Prosthetic tissue replacement, including joint replacements

    e. Implantable prosthetic lenses, in connection with cataracts

    f. Skin grafts

14. For X-rays, Magnetic Resonance Imaging (MRI), Computed Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT), and other diagnostic services. See **Radiology, Imaging and Other Diagnostic Testing** provision of this *contract*.

15. For *medically necessary telehealth services*. *Telehealth services* not provided by *Virtual 24/7 care* would be subject to the same *cost sharing* as the same health care services when delivered to a *member* in person.

16. For *surgery* or services related to cochlear implants and bone-anchored hearing aids.

17. For *medically necessary* services for complications arising from medical and surgical conditions.
18. For respiratory, pulmonary, cardiac, physical, occupational and speech therapy services. Please see **Habilitation, Rehabilitation and Extended Care Facility Benefits** provision of this *contract*.
19. For children's early intervention therapy for expenses arising from the services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists, and clinical social workers working with children from birth to 36 months of age with an identified developmental disability and/or delay.
20. For *medically necessary* footcare treatment that may require *surgery*; *prior authorization* may be required.
21. For dermatology services which are limited to the following: *medically necessary* minor *surgery*, tests and office visits provided by a dermatologist who is a *network provider*.
22. For *medically necessary* biofeedback services.
23. For services associated with human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation or transplant procedures.
24. For *medically necessary chiropractic care* or manipulative therapy treatment on an outpatient basis only.
25. For all *medically necessary* immunizations, monitoring, screenings, re-screenings, and laboratory testing for a newborn in the early detection, diagnosis and intervention of a condition or disorder. This also includes, but not limited to, hearing or audiological services, follow-up examinations and pulse oximetry.
26. For *medically necessary* allergy testing and treatment including allergy injections and serum.
27. For elective sterilization procedures (e.g., vasectomies). **NOTE:** No *cost share* applies, except on HSA-compatible plans.
28. For accidental *dental service* expenses when a *member* suffers an *injury* that results in damage to his or her natural teeth. *Injury* to the natural teeth will not include any *injury* as a result of chewing.

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

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

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

Medical Dental Services

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

Coverage is also provided for:

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

Medical Foods

We cover medical foods and formulas for outpatient total parenteral nutritional therapy; outpatient elemental formulas for malabsorption; and dietary formula when *medically necessary* for the treatment of Phenylketonuria (PKU) and inborn errors of metabolism.

The American Academy of Pediatrics recommends that infants are exclusively breastfed for approximately the first six months of life, after which complementary foods can be introduced, and to continue breastfeeding for one year or longer. Benefits will be provided for *medically necessary* pasteurized donor human milk when prescribed by an infant's pediatrician or licensed pediatric provider stating that the infant is medically or physically unable to receive maternal human milk or participate in breastfeeding or the infant's mother is medically or physically unable to produce maternal human milk in sufficient quantities.

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

Low-Protein Food Products for Treating Inherited Metabolic Diseases

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

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

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

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

Medical Vision Services

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

Vision services under the medical portion of your *contract* do not include:

1. Referrals to a *specialist physician* for evaluation and diagnosis of refractive error, including presbyopia.
2. Eye examinations required by an employer or as a condition of employment.
3. Radial keratotomy, LASIK, and other refractive eye *surgery*.

4. Services or materials provided as a result of any workers' compensation law or required by any governmental agency.
5. Orthoptics, vision training or subnormal vision aids.

Mental Health and Substance Use Disorder Benefits

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

Covered services will be provided on an *inpatient* and outpatient basis for the treatment of mental health and *substance use disorders* diagnoses. 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 *behavioral health* providers by accessing the "Find a Doctor" page at AmbetterHealth.com/en/IN or by calling Member Services. *Deductible amounts*, *copayment amounts*, or *coinsurance amounts* and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

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

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

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

Inpatient

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

Outpatient

1. Partial hospitalization program (PHP);
2. Intensive outpatient program (IOP);
3. Medication management services;
4. Outpatient detoxification programs;
5. Psychological and neuropsychological testing and assessment;

6. Evaluation and assessment for mental health and *substance use disorders*;
7. *Applied behavior analysis*;
8. Telehealth for individual/family therapy; medication monitoring; assessment and evaluation;
9. Individual and group therapy for mental health and *substance use disorders*;
10. Medication assisted treatment – combines behavioral therapy and medications to treat *substance use disorders*;
11. Mental health day treatment;
12. Electroconvulsive therapy (ECT);
13. *Transcranial magnetic stimulation* (*TMS*).

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

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

Pediatric Routine Vision Benefits – Children under the age of 19

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

1. Routine ophthalmological examination
    a. Refraction;
    b. Dilation.
2. Standard frames
3. Prescription lenses
    a. Single;
    b. Bifocal;
    c. Trifocal; or
    d. Lenticular.
4. Additional lens options (including coating and tints)
    a. Progressive lenses (standard or premium);
    b. Intermediate vision lenses;
    c. Blended segment lenses;
    d. Hi-Index lenses;
    e. Plastic photosensitive lenses;
    f. Photochromic glass lenses;
    g. Glass-grey #3 prescription sunglass lenses;

h. Fashion and gradient tinting;
i. Ultraviolet protective coating;
j. Polarized lenses;
k. Scratch resistant coating;
l. Anti-reflective coating (standard, premium or ultra);
m. Oversized lenses;
n. Polycarbonate lenses.

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

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

Services not covered:

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

Prescription Drug Benefits

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

Covered services in this benefit provision are limited to charges from a licensed, *network* 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. 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.

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

As used in this provision, 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.

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

Self-Injectable Drugs

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

Medication Balance-On-Hand

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

Formulary or Prescription Drug List

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

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

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

Over-the-Counter (OTC) Prescriptions

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

How to Fill a Prescription

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

If you decide to have your prescription 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/IN 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/IN. You can also request to have a copy mailed directly to you.

Mail Order Pharmacy/Prescription Drug Delivery

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

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

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

Extended Days' Supply

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

Non-Covered Services and Exclusions:

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

1. For *prescription drug* treatment of erectile dysfunction or any enhancement of sexual performance unless such treatment is listed on the formulary.
2. For weight loss *prescription drugs* unless otherwise listed on the formulary.
3. For medication that is to be taken by the *member*, in whole or in part, at the place where it is dispensed.
4. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
5. For a refill dispensed more than 12 months from the date of a *physician's* order.
6. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
7. For a *prescription order* that is available in over-the-counter form or comprised of components that are available in over-the-counter form and is therapeutically equivalent, except for over-the-counter products that are listed on the formulary.
8. For drugs labeled "Caution - limited by federal law to investigational use" or for *experimental or investigational* drugs.
9. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program.
10. For more than a 30-day supply when dispensed in any one prescription or refill or for maintenance drugs up to a 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply *network*. Specialty drugs and other select drug categories

are limited to a 30-day supply when dispensed by retail or mail order. **NOTE:** Only the 90-day supply may be subject to the discounted *cost sharing*. Mail orders less than 90calendar days are subject to the standard *cost sharing* amount.

11. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
12. 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.
13. 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 provision does not prohibit coverage of treatment for aforementioned diseases.
14. For medications used for cosmetic purposes.
15. For *infertility* drugs unless otherwise listed on the formulary.
16. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
17. For drugs or dosage amounts determined by Ambetter's Pharmacy and Therapy committee to be ineffective, unproven, or unsafe for the indication for which they have been prescribed, regardless of whether such drugs or dosage amounts have been approved by any governmental regulatory body for that use.
18. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
19. For any claim submitted by a non-lock-in pharmacy while *member* is in lock-in program.
20. For any drug related to *surrogate pregnancy*.
21. Medication refills where a *member* has more than 15 calendar days' supply of medication on hand.
22. Compound drugs unless there is at least one ingredient that is an FDA approved drug.
23. For immunization agents otherwise not required by the Affordable Care Act.
24. For any prescription or over-the-counter version of vitamin(s) unless otherwise included on the formulary.

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 provision the tier status as indicated by the formulary will be applicable.

Non-Formulary Prescription Drugs

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

Prescription Drug Exception Process

Standard exception request

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

Expedited exception request

A *member*, a *member's* designee 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 vial telephone. Within 24 hours of the request being received, we will provide the *member*, the *member's* designee, or the *member's* prescribing *physician* with our coverage determination. Should the standard exception or step therapy protocol exception request be granted, we will provide coverage of the non-formulary drug or the drug that is the subject of the protocol exception for the duration of the exigency.

External exception request review

If we deny a request for a standard exception or for an expedited exception, the *member*, the *member's* designee, 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* designee, or the *member's* prescribing *physician* of our coverage determination no later than three business days following receipt of the request if the original request was a standard exception and no later than one business day following its receipt of the request if the original request was an expedited exception.

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

Protocol exception for step therapy.

Requests for exceptions to step therapy protocol will be granted if any of the following apply:

1. A *preceding prescription drug* is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured.
2. A *preceding prescription drug* is expected to be ineffective, based on both of the following:
    a. The known clinical characteristics of the insured.
    b. Known characteristics of the *preceding prescription drug*, as found in sound clinical evidence.
3. The insured has previously received:
    a. a *preceding prescription drug*; or

b. another *prescription drug* that is in the same pharmacologic class or has the same mechanism of action as a *preceding prescription drug*; and

c. the *prescription drug* was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

4. Based on clinical appropriateness, a *preceding prescription drug* is not in the best interest of the *member* because the *member's* use of the *preceding prescription drug* is expected to:

   a. cause a significant barrier to the insured's adherence to or compliance with the *member's* plan of care;

   b. worsen a comorbid condition of the *member*; or

   c. decrease the *member's* ability to achieve or maintain reasonable functional ability in performing daily activities.

If the protocol exception request is denied, we will provide to the *member* and the *member's* treating health care provider notice of the denial, including a detailed, written explanation of the reason for the denial and the clinical rationale that supports the denial.

We may request a copy of relevant documentation from the *member's* medical record in support of a protocol exception.

Drug Discount, Copayment Card or Coupon

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

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

Lock-In Program

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

Split-Fill Dispensing Program

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

Preventive Care Benefits

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

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

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

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

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

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

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/IN. Either go to our website directly or if you need 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*.

For HSA-compatible plans, the *deductible amount* cannot be waived for benefits that exceed the federal ACA preventive care requirements.

Prostate Specific Antigen Testing

Medically necessary covered services include an annual digital rectal examination and prostate specific antigen test performed to determine the level of prostate specific antigen in the blood. Coverage is available to all *members*, regardless of age, when these services are rendered by a *medical practitioner*.

Radiology, Imaging and Other Diagnostic Testing

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

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

Second Medical Opinion

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

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

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

If a second medical opinion is obtained by a *non-network provider*, *prior authorization* must be obtained before services are considered an *eligible expense*. If *prior authorization* is not obtained for a second medical opinion from a *non-network provider*, you will be responsible for the related expenses and you may be *balance billed* for services received.

Sleep Studies

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

Transplant Benefits

Covered services for transplant service expenses: Transplants are a *covered service* when a *member* is accepted as a transplant candidate and pre-authorized in accordance with this *contract*. *Prior authorization* must be obtained through the *Center of Excellence*, a *network* facility or in a non-network facility approved by us when there is no *network* adequacy, before an evaluation for a transplant. We may require additional information such as testing and/or treatment before determining medical necessity for the transplant benefit. *Authorization* must be obtained prior to performing any related services to the transplant *surgery*. Transplant services must meet medical criteria as set by Medical Management policy.

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

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

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

1. Pre-transplant evaluation.
2. Pre-transplant harvesting of the organ from the donor.
3. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
4. Including outpatient *covered services* related to the transplant *surgery*, pre-transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection and other immunosuppressive drug therapy, etc.
5. Pre-transplant stabilization, meaning an *inpatient* stay to 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 participating facility.
7. Post-transplant follow-up visits and treatments.
8. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.
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 www.ambetterhealth.com/en/in/resources/handbooks-forms.html.

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 60 miles from their *residence* to the *Center of Excellence*:
2. We will pay a maximum of $10,000 per transplant service for the following services:
    a. Transportation for the *member*, any live donor, and the companion(s) to accompany the *member* to and from the *Center of Excellence*, in the United States.

b. When *member*, donor and/or companion(s) is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.

c. Maximum reimbursement for mileage is limited to the total miles traveled by the transplant recipient and by the donor and their respective companion(s) to and from their respective homes to the transplant facility, plus miles traveled:

   i. Between the transplant facility and local lodging; and

   ii. Between a transit hub (e.g., airport, train station, bus station) and either the transplant facility or local lodging.

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

Please refer to the Member Resources page for *member* reimbursement transplant travel forms and information at www.ambetterhealth.com/en/in/resources/handbooks-forms.html.

Non-Covered Services and Exclusions:

No benefits will be provided or paid under this **Transplant Benefits** provision:

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

    a. Alcohol/tobacco

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

    c. Vehicle maintenance for motorized and hybrid and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.)

d. Parking (unless pre-approved by Case Management).
e. Storage rental units
f. Temporary housing incurring rent/mortgage payments.
g. Loss of wages due to time off from work required for transplant for recipient, donor, or companion(s).
h. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
i. Moving violation tickets or parking tickets.
j. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
k. Any services related to pet care, boarding, lodging, food and/or travel expenses
l. Expenses for persons other than the transplant recipient, donor, or their respective companion(s).
m. Expenses for lodging when the transplant recipient, donor, or their respective companion(s) are staying with a relative, friend or otherwise have free lodging.
n. Any expense not supported by a receipt
o. Upgrades to first class travel (air, bus, and train).
p. Personal care items (e.g., shampoo, deodorant, clothes).
q. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA precheck and early check-in boarding fees, extra baggage fees.
r. Souvenirs (e.g., t-shirts, sweatshirts, toys).
s. Telephone calls/mobile bills, replacement parts or cellular purchases of any type.
t. All other items not described in the *contract* as *eligible expenses*.
u. Any fuel costs/charging station fees for any vehicle (but note that mileage is reimbursable).
v. Any tips, concierge, club level floors, and gratuities.
w. Salon, barber, and spa services.
x. Insurance premiums
y. *Cost share* amounts owed to the transplant surgeon or facility or other provider.

Urgent Care Services

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

Members are encouraged to contact their *primary care physician* for an appointment before seeking care from another provider, but *network urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *primary care physician* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-855-604-1303. 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 *members* that serve to remove barriers to accessing health services and improve overall health outcomes. These programs and services are available when your coverage begins and continue as long as your coverage remains active. Participation in these programs and services is optional and available at no additional cost to *members*. The programs and services are available to you as part of this *contract* but are not insurance. We may make changes to the terms and conditions of the programs and services or discontinue them at any time. Program tools and service may vary within your market. To inquire about these programs and other offerings, and to learn about what programs are available in your area, please visit our website at AmbetterHealth.com/en/IN or by contacting Member Services.

The Ambetter Health preventive care and wellness program includes offerings for health check-ups, screenings for common conditions and vaccinations. Rewards, including those that may be converted to monetary value, may be available through the “My Health Pays” program for completing specific activities that promote healthy behaviors and address *social determinants of health*. *Members* may receive communications and outreach about this program. Ambetter Health reserves the right to apply any such rewards to any unpaid premiums or related amounts you may owe.

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

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

You can access other services in connection with this *contract*, such as the “Ambetter Perks” program, which offers discounts on a wide range of activities, services, goods, financial tools, memberships, out-of-pocket prescription expenses, over-the-counter (OTC) health products, and health- and wellness-related services addressing *social determinants of health* and healthy lifestyle. *Members* are responsible for paying for the discounted goods or services and we do not endorse any vendor, goods or services associated with the program. *Members* may also have access to a zero-interest line of credit through the Ambetter Perks program for paying their *deductibles*, *copayments*, and *coinsurance amounts* on *covered services*, with several repayment options to fit their needs. The Ambetter Perks program is offered to all *members*. We are not involved in administering programs; you will communicate directly with any vendors if you choose to participate.

PRIOR AUTHORIZATION

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

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

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

Prior Authorization Required

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

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

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

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

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

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

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

1. For urgent concurrent reviews received at least 24 hours prior to the expiration of a previously approved course of treatment, within 24 hours of receipt of the request. For all other urgent concurrent reviews, within 72 hours of receipt of request.

2. For urgent pre-service reviews, within 48 hours of receipt of the request.
3. For non-urgent pre-service reviews, requests within five business days of receipt of the request.
4. For post-service or request 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 laws*.

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 denied. A *non-network provider* can balance bill you for these services.

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

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

Prior Authorization Does Not Guarantee Benefits

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

Requests for Predeterminations

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

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

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

Services from Non-Network Providers

Except when *balance billing protections* apply to a *covered service* provided by a *non-network provider*, we do not normally cover services received from *non-network providers*. If a situation arises where a *covered service* cannot be obtained from a *network provider* located within a reasonable distance, we may provide *prior authorization* for you to obtain services from a *non-network provider* at

no greater cost to you than if you went to a *network provider*. If *covered services* are not available from a *network provider*, you or 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.

Prior Authorization Denials

Refer to the **GRIEVANCE AND APPEAL PROCEDURES** section of this *contract* for information on your right to *appeal* a denied *authorization*.

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

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

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*.
2. For any portion of the charges that are in excess of the *eligible expense*.
3. For weight modification or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery* and bariatric *surgery*, except as specifically covered in the **MAJOR MEDICAL EXPENSE BENEFITS** section of this *contract*.
4. For weight loss programs, gym memberships, exercise equipment or meal preparation programs.
5. For the reversal of sterilization and the reversal of vasectomies.
6. For abortions, unless performed to save the life or health of the *member* and not illegal under *applicable law*.
7. For treatment of malocclusions disorders of the temporomandibular joint or craniomandibular disorders, except as described in the Medical and Surgical Expense Benefits provision.
8. For expenses for television, telephone, or expenses for other persons.
9. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
10. For telephone consultations between providers, except those meeting the definition of *telehealth services* or for failure to keep a scheduled appointment.
11. For stand-by availability of a *medical practitioner* when no treatment is rendered.

12. For *dental service* expenses, including braces for any medical or dental condition, *surgery*, and treatment for oral *surgery*, except as expressly provided for under medical service expense benefits.
13. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect.
14. For the following *mental health disorder* services:
    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;
    e. Evaluation for the purpose of maintaining employment. Benefits will be allowed for services that would otherwise be covered under this *contract*;
    f. Services which are custodial in nature;
    g. Habilitative services that are solely educational in nature or otherwise paid under *applicable law* for purely educational services.
15. For charges related to or in preparation for, tissue or organ transplants, except as expressly provided for under the **Transplant Benefits** provision.
16. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
17. While confined primarily to receive *rehabilitation*, *custodial care*, educational care, or nursing services (unless expressly provided for in this *contract*).
18. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy or occupational therapy, except as expressly provided for in this *contract*.
19. For eyeglasses, contact lenses, eye refraction, visual therapy or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
20. For hearing aids, except as expressly provided in this *contract*.
21. For *experimental or investigational* or *unproven services*. The fact that an *experimental or investigational* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational* or *unproven service* for the treatment of that particular condition.
22. For any injectable medication or biological product that is not expected to be self-administered by the *member* at *member's* place of *residence* unless listed on the formulary.
23. As a result of an *illness* or *injury* arising out of or in the course of, employment for wage or profit, if the *member* is insured or is required to be insured, by workers' compensation insurance pursuant to *applicable law*. If you enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's* workers' compensation claim, this exclusion will still apply unless that denial is *appealed* to the proper governmental agency and the denial is upheld by that agency.

24. For *surrogacy arrangement*. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a *member*. This exclusion applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the *surrogate* following childbirth);
    d. Mental health services related to the *surrogacy arrangement*;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
    h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement*;
    i. Any complications of the *surrogate* resulting from the *pregnancy*;
    j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*.
    k. Any and all health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except when the child possesses an active *contract* with us effective at the time of birth.
25. For fetal reduction *surgery*.
26. Except as specifically identified as a *covered service* under this *contract*, services, or expenses for alternative treatments, including acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
27. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding or accompanying others in any of the following: professional or semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); racing or speed testing any non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).
28. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or *member* of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
29. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
30. For the following miscellaneous items (except where required by federal or state law): in vitro fertilization, artificial insemination; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods provision; health club memberships, unless otherwise covered; home test kits, unless required by *applicable law*; care or services provided to a non-*member* biological

parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *rehabilitation* services for the enhancement of job, athletic or recreational performance; routine or elective care outside the *service area*; treatment of spider veins; transportation expenses, unless specifically described in this *contract*. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.

31. For court ordered testing or care unless *medically necessary* or is required by law.
32. For a *member's illness* or *injury* which is caused by the acts or omissions of a *third-party*, we will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third-party*.
33. 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.
34. For any medicinal and recreational use of cannabis or marijuana.
35. For all health care services obtained at an urgent care facility that is a *non-network provider*.
36. For expenses, services, and treatments from a Naprapathic *specialist physician* for conditions caused by contracted, injured spasmed, bruised and/or otherwise affected myofascial or connective tissue.
37. For expenses, services, and treatments from a Naturopathic *specialist physician* for treatment of prevention, self-healing, and use of natural therapies.
38. For expenses for services related to dry needling.
39. For the treatment of *infertility*, except as expressly provided in this *contract*.
40. For expenses, services and treatments related to private duty nursing in an *inpatient* location.
41. 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.
42. For Assertive Community Treatment (ACT).

TERMINATION

Termination of Contract

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

1. Non-payment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date we receive a request from you to terminate this *contract* or any later date stated in your request or if you are enrolled through the Health Insurance Marketplace, the date of termination that the Health Insurance Marketplace provides us upon your request of cancellation to the Health Insurance Marketplace.
3. The date we decline to renew this *contract*, as stated in the Discontinuance provision.
4. The date of your death if this *contract* is an individual plan.
5. For a covered *eligible child* reaching the limiting age of 26, coverage under this *contract*, will terminate on the 31st day of December the year the *eligible child* turns 26 years of age.
6. The date a *member's* eligibility for coverage under this *contract* ceases due to any of the reasons stated in the **ELIGIBILITY AND ENROLLMENT** section in this *contract*.
7. The date a *member's* eligibility for coverage under this *contract* ceases as determined by the Health Insurance Marketplace.

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 in which you enrolled.

Such cancellation shall become effective upon receipt or on such later date specified in the notice. Upon cancellation or termination of the *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.

Reinstatement

For coverage purchased outside the Health Insurance Marketplace, we will reinstate a *contract* when it is erroneously terminated or cancelled. The reinstatement will result in restoration of the enrollment with no break in coverage. For coverage purchased via the Health Insurance Marketplace, the Health Insurance Marketplace should be contacted for reinstatement.

Discontinuance

90-Day Notice: If we discontinue offering all *contracts* issued on this form, for all residents of the state where you reside, we will provide a written notice to you at least 90 calendar days prior to the date that we discontinue coverage. You will be offered an option to purchase any other coverage in the individual market we offer in your state at the time of discontinuance of this *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.

RIGHT OF REIMBURSEMENT AND SUBROGATION

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

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

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

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

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

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

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

benefits associated with *third-party injuries* provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement).

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

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

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

Ambetter may recover full cost of all benefits paid by this plan 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, you shall be responsible for all benefits paid by this plan in addition to costs and attorney’s fees incurred by Ambetter in obtaining repayment.

COORDINATION OF BENEFITS

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

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

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

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

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

The term "Plan" includes:

1. Group and non-group insurance contracts and subscriber contracts;
2. Uninsured arrangements of group or group-type coverage;
3. Group and non-group coverage through closed panel plans;
4. Group-type contracts;
5. The Medicare care components of long-term care contracts, such as skilled nursing care;
6. The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts; and
7. Medicare or other governmental benefits, as permitted by law, except as provided with a state plan under a government plan whose benefits are in excess of those of a nongovernmental plan. The part of the definition of plan may be limited to the *hospital*, medical and surgical benefits of the governmental program.

The term "Plan" does not include:

1. *Hospital* indemnity coverage benefits or other fixed indemnity coverage;
2. Accident only coverage;
3. Specified disease or specified accident coverage;
4. Limited benefit health coverage;
5. Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, *respite care* and *custodial care* or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

6. A state plan under Medicaid or a government plan that, by law, provides benefits that are in excess of those of any:
    a. private insurance plans; or
    b. other nongovernmental plan.
7. Medicare supplement policies.

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

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

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

Order of Benefit Determination Rules

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

1. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. A plan may consider benefits paid or provided by another plan in determining its benefits only when it is secondary to that *other plan*.
2. There are two exceptions:
    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987, which provides excess major medical benefits intended to supplement any basic benefits on a *member* may continue to be excess to such basic benefits.
3. Each plan determines its order of benefits using the first of the following rules that apply:
    a. **Non-Dependent or Dependent.** The plan that covers the person other than as a dependent, for example as an employee, *member*, policyholder, *subscriber*, or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, *member*, policyholder, *subscriber* or retiree is the secondary plan and the *other plan* is the primary plan.
    b. **Dependent Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:

        If a child is covered under the plans of both parents and the parents are married or living together, the plan of the parent whose birthday falls earlier in the calendar year (excluding

year of birth) shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary.

i. If a child is covered by both parents' plans and the parents are separated or divorced or do not live together, whether or not they have ever been married: If a court order or decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's *spouse* does, that parent's *spouse* is the primary plan. This rule applies to the plan years commencing after the plan is given notice of the court decree;

ii. If a court order or decree states that both parents are responsible for or orders joint custody without considering for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (i) above shall determine the order of benefits.

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

a) The plan covering the custodial parent;

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

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

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

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of subparagraphs i. or ii. above shall determine the order of benefits as if those individuals were the parents of the child.

4. **Active Employee or Retired or Laid-off Employee.** If the person receiving services is covered under one plan as an active employee (i.e., not laid-off or retired) or as the *spouse* or child of such an active employee and is also covered under another plan as a laid-off or retired employee or as the *spouse* or child of such a laid-off or retired employee, the plan that covers such person as an active employee or *spouse* or child of an active employee will be primary. If the *other plan* does not have this rule and as a result the plans do not agree on which will be primary, this rule will be ignored. This rule does not apply if the rule 3(a) can determine the order of benefits.

5. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, *member*, *subscriber*, or retiree or covering the person as a dependent of an employee, *member*, *subscriber*, or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the *other plan* does not have this rule and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 3(a) can determine the order of benefits.

6. **Longer or Shorter Length of Coverage.** The plan that covered the person longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

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

Effects of Coordination

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Ambetter's maximum allowable benefit for each *covered service*. Also, the amount Ambetter pays will not be more than the amount Ambetter would pay if Ambetter were primary. As each claim is submitted, Ambetter will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period. When this plan is secondary as a result of one of our *members* being a Medicare beneficiary, see above definition for allowable expense, as we will reduce our benefits up to Medicare's allowable.

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

Right to Receive and Release Needed Information

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

CLAIMS

Notice of Claim

We must receive notice of claim within 30 calendar days of the date the *loss* began or as soon as reasonably possible. Claim forms may be furnished by Ambetter Health within 15 calendar days after the notice of claim is received.

Proof of Loss

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

How to Submit a Claim

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

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

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

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

Cooperation Provision

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

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

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

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

Time for Payment of Claims

For services that do not fall under the federal No Surprises Act *balance billing protections*, claims will be processed within 30 calendar days for clean claims filed electronically, or within 45 calendar days for clean claims filed on paper. For services that fall under the federal No Surprises Act *balance billing protections*, we will process a clean claim within 30 calendar days of receipt regardless of how the claim was submitted. "Clean claims" means a claim submitted by you or a provider that has no defect, impropriety or particular circumstance requiring special treatment preventing payment. If we have not received the information, we need to process a claim, we will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information. In those cases, we cannot complete the processing of the claim until the additional information requested has been received. We will make our request for additional information within 30 calendar days of our initial receipt of the claim and will complete our processing of the claim within 15 calendar days after our receipt of all requested information.

Payment of Claims

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

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 provider 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* the entire period of travel, including the first 90 calendar days.

Claims incurred outside of the United States for *emergency services* must be submitted within 180 calendar days from the date of service. The claims must include clinical documentation (medical records) that supports all *emergency services* received. Claims and medical records must be submitted in English or with an English translation, at the *member's* expense to show proper *proof of loss* and evidence of any payment(s) to the provider. Proof of departure from and arrival to the United States must be submitted with the claim. These documents must be submitted with the Member Reimbursement Medical Claim Form, along with all requested documents as detailed on the claim form. All forms and *member* resources are available at AmbetterHealth.com/en/IN.

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

cost share, and currency exchange rate at the time of the transaction. The Explanation of Benefits will detail the *member's* responsibility and any eligible reimbursement.

Assignment

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

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

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

Medicaid Reimbursement

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

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

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

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

Custodial Parent

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

Upon request by the custodial parent, we will:

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

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

Physical Examination

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

Legal Actions

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

Non-Assignment

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

Notwithstanding the foregoing, you may specifically authorize, in writing, the payment of benefits that we have determined to be due and payable directly to any *hospital*, provider or other person who provided you with any *covered service* and we will honor this specific direction and make such payment directly to the designated provider of the *covered service*.

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.

APPEAL AND GRIEVANCE PROCEDURES

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

Call Member Services

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

Appeal

An *appeal* is a request for a review of a decision we made to deny, reduce, or terminate a requested service. These are known as *adverse benefit determinations*. You can *appeal* these decisions. You can designate a representative –such as a family member, friend, *physician*, or attorney to *appeal* these decisions on your behalf.

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

You can submit your written *appeal* with supporting information by mail or fax to:

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

You may also initiate an *appeal* orally by calling Member Services. Your verbal submission should be followed up with a written and signed request.

Call us at 1-877-687-1182 (TTY 1-800-743-3333) if you have any questions regarding the process or how to file an *appeal*. If needed, we can provide an interpreter or teletypewriter (TTY) service for you.

We will acknowledge your request within three business days of receipt of your *appeal* and will notify you if any additional information is required to complete our review. You will be informed that you can present any information that you wish for us to consider as part of the *appeal*.

Your *appeal* will be handled by a person who was not involved in the initial review, has knowledge of the medical condition, procedure, or treatment, and who is licensed in the same profession and similar specialty as the provider who recommended or delivered the health care procedure, treatment, or service under review.

We will make a decision within 30 calendar days of receipt of your *appeal*. With your consent, we may extend this timeframe an additional 14 calendar days if you request the extension or we need additional information to reach a decision and the delay is to your benefit. A written notice will be provided within five business days after we make a decision.

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

You will be provided, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the *member's* claim for benefits. All comments, documents, records, and other information submitted by the *member* relating to the 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*.

You will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer and any new or additional medical rationale considered by the reviewer.

Expedited Appeal

You can file an expedited *appeal* when a requested service involves a situation that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. You will need to provide documentation from your provider that supports the urgent need or situation.

You may initiate an expedited *appeal* orally by calling Member Services or you can submit a written request by mail or fax. All necessary information, including our decision, will be transmitted to you by telephone, fax, or other expeditious method available. An expedited *appeal* shall be resolved as quickly as possible and as your health condition requires, but not more than 48 hours after receipt of the *appeal*.

Due to the 48-hour resolution timeframe, the standard requirements for an acknowledgement notification or right to appear before a panel does not apply to expedited *appeals*.

External Review

If you or your *authorized representative*, are not satisfied with the final outcome of the internal *appeal*, an external review by an Independent Review Organization (IRO) may be requested. You or your *authorized representative*, can request an external review when the *appeal* is of *adverse benefit determinations* based on medical necessity, appropriateness, health care setting, level of care or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. Filing an external review will not affect your health care services. We want to know your concerns so we can improve our services.

An external review decision is binding on us. You shall not pay any of the costs associated with the services of the IRO.

Applicability/Eligibility

The external review *appeals* procedures apply to:

1. Any *hospital* or medical policy or certificate; excluding accident only or disability income only insurance.
2. The request for an IRO must be submitted within four months from the date of the notice of action regarding their expedited or standard *appeal* (or per state timeframes if more stringent). The request must be submitted within 10 calendar days of the date of the notice of resolution if the *member* wishes to have continuation of benefits during the external independent review. The plan will assist the *member* or their representative with filing the *appeal*, as requested.
3. *Members* may request an expedited external review from an IRO should the issue at question be related to disease, *illness*, *injury*, health condition or a disability that the decision would seriously jeopardize the individual's health, life, or ability to reach or maintain maximum function.

External review is available for *appeals* that involve:

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

External Review Process

We have 15 business days following receipt of the request to provide a final and binding decision made by the IRO to the individual. The decision from the IRO will be based upon information from the insurer, the insured individual or *authorized representative*, the treating health care provider, and any other information the IRO deems appropriate and relevant to the issue.

The IRO will also provide notification to the individual and the health plan within 72 hours of completion of their review. The IRO will include:

1. A clear statement of the binding decision;
2. Standards used in the decision, including objective clinical evidence; and
3. Any applicable terms or eligibility of the individual's insurance policy.

Expedited External Review Process

An expedited external review may be requested by the *member* should the issue be thought to seriously jeopardize the individual's health or life or ability to maintain or achieve maximum function. An expedited review will follow the same process as outline above. For an expedited external review, both the determination and notification to the *member* and covered person must be provided within 72 hours of the claim being filed.

Member Rights and Responsibilities When Requesting an External Review

You have the right to request an external review provided by an Independent Review Organization (IRO). We will cover all costs associated with an external review. You shall not face any type of retaliation from us for filing an external review. You may continue to utilize any other *covered services* associated with your health insurance contract. You may also submit any new or additional information as a part of the external review process for further consideration of your *appeal*. You are expected to cooperate with any requests from the IRO, such as providing any requested medical information or signing releases for additional medical records. We will also fully cooperate with the IRO for any such requests of information related to the *appeal* or your care provided by us.

You may also request your case information from the IRO to better understand the effect of the determination and what response you should expect from us.

Questions regarding your *contract* or coverage should be directed to Member Services.

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone, or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: 1-800-622-4461; 1-317-232-2385
Complaints can be filed electronically at https://www.in.gov/idoi/.

Standard Grievances

A *grievance* is an expression of dissatisfaction about anything other than an *adverse benefit determination*. *Grievances* may refer to any dissatisfaction about:

1. Us, as the insurer; e.g., customer service *grievances* - “the person to whom I spoke on the phone was rude to me;”
2. Providers with whom we have a direct or indirect contract;
    a. Lack of availability and/or accessibility of *network providers* not tied to an unresolved benefit denial; and
    b. Quality of care/quality of service issues;
3. Expressions of dissatisfaction regarding quality of care/quality of service.

You have 180 calendar days from the event to file a *grievance* with us. You or your *authorized representative* may file a *grievance* by calling Member Services or in writing by mailing or faxing your *grievance* to:

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

If filing a written *grievance*, please include:

1. Your first and last name
2. Your *member* identification number
3. Your address and telephone number
4. Details surrounding your concern
5. Any supporting documentation

Standard grievances will be acknowledged within three business days of receipt. We will promptly investigate and notify you of the outcome of the *standard grievance* in writing within 20 business days of initial receipt. The time period may be extended for an additional 10 business days, making the maximum time for the entire *grievance* process 30 business days. If an extension is necessary, we will provide you or your *authorized representative*, if applicable, written notification of the following within the first 20 calendar days:

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

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

Appeals and Grievances Filing and Key Communication Timelines

	Timely Filing	Acknowledgement	Resolution	Allowable Extension
Standard Grievance	180 Calendar Days	3 Business Days	20 Business Days	10 Business Days
Standard Pre-Service Appeal	180 Calendar Days	3 Business Days	30 Calendar Days	14 Calendar Days
Expedited Pre-Service Appeal	180 Calendar Days	N/A	48 Hours	14 Calendar Days
Standard Post-Service Appeal	180 Calendar Days	3 Business Days	30 Calendar Days	14 Calendar Days
External Review	4 Months	4 Months	15 Business Days	N/A
Expedited External Review	4 Months	4 Months	72 Hours	N/A

GENERAL PROVISIONS

Entire Contract

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

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

Non-Waiver

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

Rescissions

No misrepresentation of fact made regarding a *member* during the enrollment 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 enrollment application, including amendments, signed by a *member*;
2. A copy of the enrollment 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, Misrepresentation or False Information

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

Personal Health Information (PHI)

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

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

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

Language Assistance

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