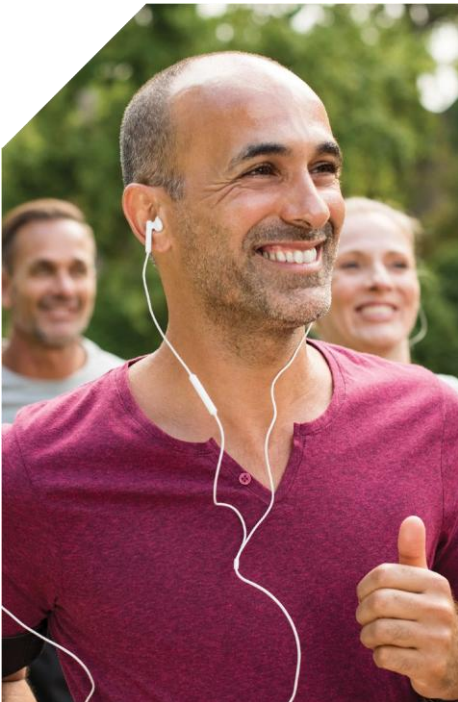




2027 EVIDENCE OF COVERAGE



[Ambetterhealth.com](https://www.Ambetterhealth.com)

Ambetter Health Solutions

Individual EPO Health Benefit Plan

Issued and Underwritten by Bankers Reserve Life Insurance Company of Wisconsin

Home Office: 7711 Carondelet Ave. St. Louis, MO 63105

Individual Member Contract

In this *contract*, "you" or "your" will refer to the *subscriber* and/or any dependents enrolled in this *contract* and "we," "our," or "us" will refer to Ambetter Health.

RIGHT TO RETURN CONTRACT

Please read your *contract* carefully. If you are not satisfied, return this *contract* to us or to our agent within ten calendar days after you receive it. All premiums paid will be refunded, less claims paid, and the *contract* will be considered null and void from the *effective date*.

AGREEMENT AND CONSIDERATION

We issued this *contract* and the corresponding *Schedule of Benefits* in consideration of the enrollment application and the payment of the first premium. We will provide benefits to you, the *member*, for covered *losses* due to *illness* or bodily *injury* as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

This *contract*, including the endorsements and the attached papers, if any, constitutes the entire *contract* of insurance. No change in this *contract* shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this *contract* or to waive any of its provisions.

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* is found to be in material breach of this *contract*; or (3) 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 will change the rate table used for this *contract* form. Each premium will be based on the rate table in effect on that premium's due date. The *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.

This health benefit plan requires that all *health care services* be delivered by a *network provider*. Services rendered by a *non-network provider* are not covered under this plan, except for *emergency services* and two (2) sessions per year to a licensed psychiatrist, licensed psychologist, licensed professional counselor or a licensed clinical worker for the purpose of diagnosis or assessment of mental health.

As a cost containment feature, this *contract* contains *prior authorization* requirements. 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.

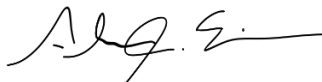
WARNING: If you or your family *members* are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and *hospitals*, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any *other plan* that covers you or your family.

IMPORTANT INFORMATION

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

The coverage represented by this *contract* is under the jurisdiction of the Missouri Department of Commerce and Insurance.

Should this *contract* be purchased outside of the Health Insurance Marketplace, then any and all references to Health Insurance Marketplace are not applicable.



Alan J. Silver,
President ,
Ambetter Health Solutions

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INTRODUCTION

Welcome to Ambetter Health (“Ambetter”)! This *contract* is issued and underwritten by Bankers Reserve Life Insurance Company of Wisconsin, and *network* access and administrative services are provided by Ambetter Health.

We have prepared this *contract* to help explain your coverage. Please refer to this *contract* whenever you require medical services. It describes how to access medical care, the *health care services* we cover, and the portion of your health care costs you will be required to pay.

This *contract*, the *Schedule of Benefits*, and the enrollment application, including any amendments and 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 of this *contract* 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 healthcare setting – these words are italicized and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. This *contract* also contains exclusions, so please be sure to read this entire *contract* carefully.

How to Contact Us

Ambetter Health Solutions
7711 Carondelet Ave.
St. Louis, MO 63105

Normal Business Hours of Operation 7:00 a.m. to 6:00 p.m. Central Standard Time, Monday through Friday.

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

Interpreter Services

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

Our interpreter services are provided at no cost to you. We have medical interpreters to assist with languages other than English via phone. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for oral interpretation, or to request materials in Braille or large font.

Members who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation. To arrange for interpretation services, call Member Services.

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

If you have difficulty locating a *primary care physician* (“PCP”), *specialist 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 Ambetter coverage requires you to use contracted providers with limited exceptions. You can access the online directory at [Ambetterhealth.com](https://www.ambetterhealth.com).

You have the right to:

1. Participate with your providers in decisions about your health care. This includes working on any treatment plans and making care decisions. You should know any possible risks, problems related to recovery, and the likelihood of success. You shall not have any treatment without consent freely given by you or your legally *authorized representative*. You will be informed of your care options.
2. Know who is approving and performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which you have coverage.
4. Be treated with respect and dignity.
5. Privacy of your personal health information, consistent with state and federal laws, and our policies.
6. Receive information or make recommendations, including changes, about our organization and services, our *network of 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. Voice *complaints* or *appeals* about our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
9. See your medical records.
10. Be kept informed of covered and non-covered services, program changes, how to access services, providers, advance directive information, *authorizations*, benefit denials, *member* rights and responsibilities, and our other rules and guidelines. We will notify you at least 60 calendar days before the *effective date* of the modifications. Such notices shall include the following:
 - a. Any changes in clinical review criteria; or
 - b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
11. A current list of *network providers*.
12. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
13. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, ethnicity, race, religion, gender, sexual orientation, national origin, physical or mental disability, or genetic status.
14. Access *medically necessary* urgent and *emergency services* 24 hours a day and seven days a week.
15. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.
16. Refuse treatment to the extent the law allows without jeopardizing future treatment and be informed by your *medical practitioner(s)* of the medical consequences. You are responsible for your actions if treatment is refused or if the *physician's* instructions are not followed. You should discuss all concerns about treatment with your *physician*. Your *physician* can discuss different treatment plans with you, if there is more than one option that may help you. You will make the final decision.
17. Select your *PCP* within the *network*. You also have the right to change your *PCP* or request information on *network providers* close to your home or work.
18. Know the name and job title of people giving you care. You also have the right to know which *physician* is your *PCP*.
19. An interpreter when you do not speak or understand the language of the area.
20. A second opinion by a *network provider*, if you want more information about your treatment or would like to explore additional treatment options.
21. Make advance directives for health care decisions. This includes planning treatment before you need it. Advance directives are forms you can complete to protect your rights for medical care. It can help your *PCP* and other providers understand your wishes about your health. Advance directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself. *Members* also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive. Examples of advance directives include:
 - a. Living Will

b. Health Care Power of Attorney

c. "Do Not Resuscitate" Orders.

You have the responsibility to:

1. Read the entire *contract*.
2. Treat all *physicians* and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about your health that we or your *medical practitioners* need in order to provide care. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your *physician* until you understand the care you are receiving.
4. Review and understand the information you receive about us. You need to know the proper use of *covered services*.
5. Show your *member* identification card and keep scheduled appointments with your *physician*, and call the *physician's* office during office hours whenever possible if you have a delay or cancellation.
6. Know the name of your *PCP*. You should establish a relationship with your *physician*. You may change your *PCP* verbally or in writing by contacting Member Services. You should establish a relationship with your *physician*.
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. Understand your health problems and participate, along with your *health care professionals* in developing mutually agreed upon treatment goals to the degree possible.
9. Follow the treatment plans and instructions for care that you have agreed on with your *physicians*.
10. Tell your *physician* if you do not understand your treatment plan or what is expected of you. You should work with your *physician* 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.
11. Follow all health benefit plan guidelines, provisions, policies and procedures.
12. Use any emergency room only when you think you have a medical emergency. For all other care, you should call your *PCP*.
13. Provide all information about any other medical coverage you have upon enrollment in this plan. If, at any time, you get other medical coverage besides this coverage, you must tell the entity with which you enrolled.
14. Pay your monthly premiums, *deductible amount*, *copayment amounts*, and *coinsurance amounts* on time.
15. 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 *contract* to another *contract*.

IMPORTANT INFORMATION

Provider Directory

A listing of *network providers* is available online at guide.ambetterhealth.com. We have *network 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, 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.

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

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

At any time, you can request a copy of the provider directory at no charge by calling Member Services. 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.

Member Identification Card

We will mail you a *member* identification card after we receive your completed enrollment materials and you have paid your initial premium payment. This card is proof that you are enrolled in an 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 this *contract*.

The *member* identification card will show your name, *member* identification number, the phone numbers for Member Services, pharmacy, and 24/7 Nurse Advice Line, and *copayment amounts* required at the time of service. If you do not get your *member* identification card within a few weeks a temporary identification card can be downloaded from your secure consumer dashboard at member.ambetterhealth.com.

Website

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

1. Finding a *network provider*, including *hospitals* and pharmacies.
2. Our programs and services, including programs to help you get and stay healthy.

3. A secure portal for you to check the status of your claims, make payments and obtain a copy of your *member* identification card.
4. *Member* Rights and Responsibilities.
5. Notice of Privacy Practices.
6. Current events and news.
7. Our Formulary or *Prescription Drug* List.
8. Selecting a *primary care physician*.
9. *Deductible* and *copayment* accumulators.

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. 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 *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, preventive health screenings, and immunizations.
4. A Quality Improvement Committee that includes *network providers* to help us develop and monitor our program activities.
5. Investigating any *member* concerns regarding care received.

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

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 that are 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 calendar days per week, while the *member* is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *extended care facility*.

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

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

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

Alcohol treatment facility means a residential or nonresidential *facility* certified by the Missouri Department of Mental Health for treatment of alcohol abuse.

Allowed amount (also see *eligible service expense*) is the maximum amount we will pay a provider for a *covered service*. When a *covered service* is received from a *network provider*, the *allowed amount* is the amount the provider agreed to accept from us as payment for that particular service. In all cases, the *allowed amount* will be subject to *cost sharing* (e.g., *deductible*, coinsurance and *copayment*) per the *member's* benefits. This amount excludes agreed to amounts between the provider and us as a result of Federal or State Arbitration.

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

Ambetter-designated Telehealth Provider means the vendor selected by Ambetter to *contract* with providers to render *telehealth services*, including *Virtual 24/7 Care* benefits, to *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 center means any *facility* with a medical staff of *physicians* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This includes *ambulatory surgical centers*. 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 written *complaint* regarding:

1. Claims payment, handling or reimbursement for *health care services*; or
2. A *complaint* regarding an adverse determination made pursuant to *utilization review*.

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

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

Autism spectrum disorder means a neurobiological disorder, an *illness* of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. It is a 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.

Authorization or **authorized** means our decision to approve the medical necessity or the appropriateness of care for a *member*.

Authorized representative means an individual who represents a *member* who is any of the following:

1. A person to whom a *member* 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 *member*; or

3. A family *member* or a treating *physician*, but only when the *member* is unable to provide consent.

Autologous bone marrow transplant or **ABMT** means a procedure in which the bone marrow infused is derived from the same person who is the transplant recipient and includes peripheral blood stem cell transplants.

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

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

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

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

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

Behavioral health means both mental health and *substance use 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 is the amount a provider charges for a service.

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

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

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

Claimant is the *member* or the *member's authorized representative*, or any individual, corporation, association, partnership, or other legal entity asserting a right to payment arising out of a *contract* or a

contingency or *loss* covered under a health benefit plan, or who has contacted the plan to file a *complaint* or *appeal* or who has contacted the Missouri Department of Commerce and Insurance to file an external review.

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

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

Complications of pregnancy means an emergency cesarean section or a *non-elective cesarean section*, or a condition whose diagnoses are distinct from *pregnancy* but are adversely affected by *pregnancy* or are caused by *pregnancy*. This includes ectopic *pregnancy*, spontaneous abortion, preeclampsia, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity.

Complications of pregnancy shall be treated in the same manner as any other *illness* or sickness under this *contract*. Conditions associated with *pregnancy*, including those involving the management of a difficult *pregnancy*, shall not be subject to any exclusion, limitation, or differential treatment that is not applied to other *illnesses* or medical conditions of comparable severity.

Concurrent review means *utilization review* conducted during a patient's *hospital* stay or course of treatment.

Continuing care patient means an individual who, with respect to a provider or *facility*, is undergoing a treatment for a *serious and complex condition* from that provider or *facility*; is undergoing a course of institutional or *inpatient* care from that provider or *facility*; is scheduled to undergo non-elective *surgery* from that provider, including postoperative care; is pregnant and undergoing a course of treatment for the *pregnancy*; or is or was determined to be *terminally ill* and is receiving treatment for such *illness*.

Contract when italicized, refers to this *contract* as issued and delivered to you. It includes the attached pages, the enrollment applications, the *Schedule of Benefits*, and any amendments or riders.

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

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

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

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

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

Custodial care means treatment designed to assist a *member* with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from an *illness* or bodily *injury*. *Custodial care* includes (but is not limited to) the following:

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

Deductible amount or **deductible** means the amount that you must pay in a *calendar year* for *covered 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 you satisfy your individual *deductible amount* or your family satisfies the family *deductible amount* for the *calendar year*.

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

The *deductible amount* does not include any *copayment amounts*.

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 we must agree in writing to add them as a *dependent member*.

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

Effective date means the applicable 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, is unmarried, is a resident of the state of Missouri, and is not provided coverage as a named *subscriber*, insured, *member*, or covered person under any group or individual health benefit plan, or entitled to benefits under Title XVIII of the Social Security Act, P.L. 89-97, 42 U.S.C. Section 1395, et seq. 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, your *spouse*, or domestic partner, or
6. A stepchild.

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

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

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

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

Emergency services means *covered services* needed to evaluate and *stabilize* an *emergency condition*. This includes a medical screening examination in a *hospital* emergency department or independent freestanding emergency department to evaluate the *emergency condition*, as well as services needed to *stabilize* the *emergency condition*. Services to *stabilize* an *emergency condition* can be provided in any department of a *hospital*, and shall not be limited to, *health care services* that are provided in a licensed *hospital's* emergency *facility* by an appropriate provider.

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. Administration (FDA) regulation, regardless of whether the trial is subject to FDA oversight;
2. An *unproven service*;
3. Subject to FDA approval, and:
 - a. It does not have FDA approval;
 - b. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation;
 - c. It has FDA approval, but is being used to treat a condition, or for a use, 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*; or
 - d. 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*.
4. *Experimental or investigational* according to the provider's research protocols.

Items three and four above do not apply to phase III or IV FDA clinical trials.

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

Facility means any medical or *behavioral health* services organization or institution providing *health care services* or a health care setting that allows individuals to be treated on an *inpatient* or *outpatient* basis. This includes but is not limited to ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; extended care facilities; alcoholism treatment facilities; surgical facilities; *habilitation* and *rehabilitation* facilities; and *hospitals* or other licensed *inpatient* centers.

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

If no credible scientific evidence is available, then standards that are based on *physician* specialty society recommendations or professional standards of care may be considered. We reserve the right to consult medical professionals in determining whether a *health care service*, supply, or drug is *medically necessary* and is a *covered 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. We may use the World Health Organization's International Classification of Diseases (ICD) and the American Psychiatric Association's Diagnostic and Statistical Manual for Mental Disorders (DSM) to inform *generally accepted standards of medical practice*.

Grievance means a written *complaint* submitted by or on behalf of a *member* regarding the:

1. Availability, delivery or quality of *health care services*, including a *complaint* regarding an adverse determination made pursuant to *utilization review*;
2. Claims payment, handling or reimbursement for *health care services*; or
3. Matters pertaining to the contractual relationship between a *member* and a health carrier.

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

Health care professional means a licensed *medical practitioner*, *physician*, psychologist, nurse practitioner, *behavioral health* practitioner, or other health care practitioner licensed, accredited, or certified to perform *health care services* consistent with state law. A *health care professional* does not include someone who is related to a *member* by blood, marriage or adoption or who is normally a *member* of the *member's* household.

Health care service(s) means a service for the diagnosis, prevention, treatment, cure or relief of a health condition, *illness*, *injury* or disease, including but not limited to the provision of drugs or *durable medical equipment*.

Hearing loss, also referred to as **loss or impairment of speech or hearing**, means those communicative disorders generally treated by a speech pathologist, audiologist or speech/language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both, and which fall within the scope of his or her license or certification.

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 provided by a *home health care agency* and prescribed and supervised by a *physician*.

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

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

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

Hospital means an institution that:

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

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

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

Independent review organization (IRO) means an entity that is accredited by a nationally recognized private accrediting organization to conduct independent external reviews of *adverse benefit determinations* and by the Missouri Department of Commerce and Insurance in accordance with Missouri law.

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

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

Intensive care unit means that part of a *hospital* service specifically designed as an *intensive care unit* permanently equipped and staffed to provide more extensive care for critically ill or injured patients than available in other *hospital* rooms or wards, the care to include close observation by trained and qualified personnel whose duties are primarily confined to the part of the *hospital* for which an additional charge is made.

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

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

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

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

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

Medical practitioner includes but is not limited to a *physician*, nurse anesthetist, *physician's* assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *contract*: rolfer, hypnotist, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Medically necessary means, based on our determination, any medical service, items, supply or treatment to diagnose and treat a *member's illness* or *injury*:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to *generally accepted standards of medical practice*;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *member*;
5. Is not *experimental or investigational*;
6. 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
7. 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 service expenses*.

Member means an individual covered by the health plan including a *member*, *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 - excluding those mental or behavioral disorders due to psychoactive substance use (or equivalent category) - that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Minimum essential coverage means any health insurance plan that meets the Affordable Care Act (ACA) requirement(s) for health insurance coverage. Examples include, job-based plans, Health Insurance Marketplace ("Marketplace") plans, most individual plans sold outside of the Marketplace,

Medicare, Medicaid, Children Health Insurance Program (CHIP), TRICARE, COBRA and plans sold through the Small Business Health Insurance Program (SHOP) Marketplace.

Necessary medical supplies mean medical supplies that are necessary for the care or treatment of an *injury* or *illness*.

They do not include reusable or *durable medical equipment* and 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.

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

Network means a group of providers or facilities (including, but not limited to *hospitals*, *inpatient* mental healthcare facilities, medical clinics, *behavioral health* clinics, acupuncturists, chiropractors, massage therapists, nurse practitioners, addiction medicine practitioners, etc.) who have contracts with us, or our contractor or subcontractor, and have agreed to provide *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 service expense means the *eligible service expense* for services or supplies that are provided by a *network provider*. For *facility* services, this is the *eligible service expense* that is provided at and billed by a *network facility* for the services of either a *network* or *non-network provider*. *Network eligible service expense* includes benefits for emergency health services even if provided by a *non-network provider*.

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

Non-elective cesarean section means cesarean section where vaginal delivery is not a medically viable option or is a repeat cesarean section.

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

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

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

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

2. The *non-network provider* provides the notice described above to the *member* at least 72 hours before the services are furnished, except that for services scheduled within 72 hours, the notice must be provided at least three hours before the services are furnished.
3. The *member* provides written consent to be treated by the *non-network provider* that includes the following:
 - a. The *member's* acknowledgement that they have been provided written notice as described above and informed that payment of the *non-network provider's billed amount* may not accrue toward the *member's deductible or maximum out-of-pocket amount*;
 - b. The *member's* statement that by signing the consent, they agree to be treated by the *non-network provider* and understand they may be balance billed and subject to *cost sharing* that applies to *non-network providers* ; and
 - c. The time and date on which the *member* received the written notice and signed the consent to receive services from the *non-network provider*.
4. The *member's* consent is provided voluntarily, obtained by the *non-network provider* in the format required by *applicable law*, and not revoked by the *member* before the services are provided.
5. The *non-network provider* provides the *member* the notice document and the consent document together, but physically separate from other documents.
6. The *non-network provider* provides the *member* a copy of the signed written *notice and consent* through email or mail.

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

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

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

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

Outpatient or **outpatient services** mean that you are receiving treatment while not an *inpatient*. Services considered *outpatient* include, but are not limited to, services in an emergency room or *ambulatory surgical center* regardless of whether you are subsequently registered as an *inpatient* in a health care *facility*.

Outpatient contraceptive services means consultations, examinations, and medical services, provided on an *outpatient* basis and related to the use of contraceptive methods, to prevent *pregnancy*, which has been approved by the United States Food and Drug Administration (FDA).

Physician means a *medical practitioner*, *behavioral health* practitioner, or other health care practitioner licensed, accredited, or certified by the state of Missouri to perform specified health services consistent with state law. A *physician* does not include someone who is related to a *member* by blood, marriage or adoption or who is normally a *member* of the *member's* household.

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

Post-service claim means any claim for a benefit under this *contract* that has already been provided.

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

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

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

Prescription drug deductible amount means the amount of *covered service expenses*, shown in 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 *member* has met the individual *prescription drug deductible amount*, any remaining family *prescription drug deductible amount* can be met with the combination of any one or more *member's eligible service expenses*.

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

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

Prior authorization means a certification made pursuant to a *prior authorization review* or notice as required by a health carrier or *utilization review* entity prior to the provision of *health care services*.

Prior authorization review means a *utilization review* conducted prior to an admission or a course of treatment, including but not limited to pre-admission review, pretreatment review, *utilization review*, and case management.

Proof of loss means information required by us to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, medical bills or records, *other plan* information, 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*, *extended care facility*, or other healthcare facility.

Qualified individual means individual who has been determined eligible to enroll in a health plan in the individual market.

Rescission means a cancellation or discontinuance of coverage that has a retroactive effect. "Rescission" does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

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

Rehabilitation facility means an institution or a separate identifiable *hospital* unit, section, or ward that is licensed by the state as a *rehabilitation facility*. It 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 medical practitioner means a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation 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.

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.

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 (RTF) means a *facility* in which 24-hour, on-site and structured care (non-acute care) is provided for the evaluation, stabilization and treatment of substance use and *mental health disorders*. RTFs do not provide acute care. They are generally used as a step-down from more intensive/acute care settings. **NOTE:** The duration of stay covered under this *contract* for an RTF admission is based on medical necessity.

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

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

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

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

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

Service area means a geographical area, made up of counties, where we have been authorized by the State of Missouri 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 our Member Services department.

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

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

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

Spouse means the person to whom you are lawfully married.

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

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

Substance use disorder means a condition that falls under any of the diagnostic categories listed as a mental or behavioral disorder due to psychoactive substance use (or equivalent category) in the mental, behavioral and neurodevelopmental disorders chapter of the most current version of the International Classification of Diseases or that is listed as a substance-related and addictive disorder in the most current version of the Diagnostic and Statistical Manual of Mental Disorders.

Surgery or **surgical procedure** means an invasive diagnostic procedure or the treatment of a *member's illness* or *injury* by manual or instrumental operations, performed by a *physician* while the *member* is under general or local anesthesia.

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

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

Surrogate pregnancy means a *surrogate pregnancy* is one in which a woman has agreed to become pregnant with the intention of surrendering custody of the child to another person.

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.

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

Terminally ill means a *physician* has given a prognosis that a *member* has 12 months or less to live.

Third-party means a person or other entity that is or may be obligated or liable to the *member* for payment of any of the *member's* expenses for *illness* or *injury*. The term "*third-party*" includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. However, the term "*third-party*" will not include any insurance company with a policy under which the *member* is entitled to benefits as a named *member* or an insured *dependent member* 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 *tobacco* on average four or more times per week and within no longer than the six months immediately preceding the date the enrollment 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 that are determined not to be effective for treatment of the medical condition, and/or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or well-conducted cohort studies in the prevailing published peer-reviewed medical literature.

1. "Well-conducted randomized controlled trials" means that two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.
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 set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, *health care services*, procedures, or settings. Techniques may include ambulatory review, *prior authorization review*, second opinion, certification, *concurrent review*, *care management*, discharge planning or *retrospective review*. *Utilization review* shall not include elective requests for clarification of coverage.

Utilization review entity refers to Ambetter, as this is the entity that will perform *prior authorization reviews* for requested services.

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 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 a *member* for the purposes of adoption, or a *member* assumes total or partial financial support of the child;
5. The date a foster child is placed in your custody; or
6. The date a domestic partnership is established pursuant to state law.

We cannot deny enrollment of an *eligible child* on the grounds that that child was born out of wedlock, or the child is not claimed as a dependent on the parent's federal income tax return, or the child does not reside with the parent or in the *subscriber's service area*.

Effective Date for Initial Dependents

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

Coverage for a Newborn Child

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

The coverage for newly born children shall consist of coverage of *injury* or *illness* including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st calendar day after the date of birth. If notice of the newborn is given to us within the 31 calendar days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 calendar days after the birth of the child. If notice is given to us within 60 calendar days of the birth of the child, we may not deny coverage of the child due to failure to notify us of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st calendar day after birth, unless we have received notice from you. If you have requested enrollment application materials from us, we will allow up to ten additional calendar days of coverage after the original 31 calendar days of coverage in order for you to complete the forms and submit them to us.

Coverage for an Adopted Child

An *eligible child* legally placed for adoption with a *member* will be covered from the date of birth if a petition for adoption is filed within 31 calendar days of the birth of such child, or 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 on the same basis as any other dependent. Coverage shall include the necessary care and treatment of medical 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. The required premium will be calculated from the date of placement for adoption. Coverage of the child will terminate on the 31st calendar day following placement, unless we have received both: (A) Notification of the addition of the child 60 calendar days of the birth or placement and (B) any additional premium required for the addition of the child within 90 calendar days of the date of placement.

As used in this provision, "placement" means the date that you or your *spouse* assume physical custody of the child for the purpose of adoption pursuant to an adoption proceeding.

Adding Other Dependents

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

ELIGIBILITY AND ENROLLMENT

For All Members

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

1. The date of a *member's* death;
2. The primary *subscriber* resides outside the *service area* or moving permanently outside the *service area* of this *contract*;
3. The date that a *subscriber* is no longer within the Grace Period based on a failure to make timely payment. See the Grace Period provision for additional details;
4. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or
5. The date of termination that you provide us upon your request of cancellation to us, or, the date we receive a request from you to terminate this *contract*, or any later date stated in your request.

If you have material modifications (examples include a change in life event (marriage, death) or family status), or questions related to your health insurance coverage, contact the Member Services Department.

For Dependent Members

A *dependent member* will cease to be a *member* at the end of the premium period in which he or she ceases to be your *dependent member* due to divorce or if a child ceases to be an *eligible child*. For *eligible children*, coverage will terminate the 31st day of December the year that the dependent turns 26 years of age.

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

1. Incapable of self-sustaining employment due to mental or physical disability that began before the age limit was reached; and
2. Mainly dependent on the primary *member* for support.

Open Enrollment

Each year, there will be an open enrollment period where you may apply for or change coverage for yourself and/or your eligible dependents. The open enrollment period begins on November 1st of the current year and extends through January 15th of the following year. Coverage for *qualified individuals* who enroll on or before December 15th will have an *effective date* of coverage of January 1st of the following year.

Coverage under this *contract* is contingent upon timely receipt of any necessary information and the initial premium

Special Enrollment Periods

In general, a *qualified individual* has 60 calendar days to report certain life changes, known as "qualifying events" to us or by using Ambetter's Enrollment tool. *Qualified individuals* may be granted

a Special Enrollment Period where they may enroll in or change to a qualifying health plan during the current plan year if they have a qualifying event. Qualifying events include:

1. A *qualified individual* or dependent loses *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'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 applicable state authority, or us;
4. A *member* or dependent adequately demonstrates to the applicable state authority that the plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the *member*;
5. 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;
6. 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;
7. A *qualified individual* or *member* demonstrates to the applicable state authority, in accordance with guidelines issued by Health and Human Services (HHS), that the individual meets other exceptional circumstances as the applicable state authority may provide;
8. 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;
9. 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;
10. 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);
11. 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;

12. 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 federal poverty level 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;
13. A *member* or *dependent member* enrolled in the same plan has a change in eligibility for *cost sharing* reductions.

At the option of the Exchange, the *qualified individual*, or his or her dependent:

1. Experiences a decrease in household income;
2. Is newly determined eligible by the Exchange for advance payments of the premium tax credit; and
3. 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.

To determine if you are eligible and apply for a Special Enrollment Period, please visit [Healthcare.gov](https://www.healthcare.gov) and search for “special enrollment period.” The Health Insurance Marketplace is responsible for all healthcare 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* loses *minimum essential coverage*, coverage is effective on the first day of the following month.

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

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

If a *qualified individual*, *member*, or dependent newly gains access to an ICHRA or is newly provided a QSEHRA, and if the plan selection is made before the day of the triggering event, coverage is

effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If the plan selection is made on or after the day of the triggering event, coverage is effective on the first day of the month following plan selection.

If a *qualified individual, member*, or dependent did not receive timely notice of an event that triggers eligibility for a special enrollment period, and otherwise was reasonably unaware that a qualifying event occurred, we 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, we 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 agreement, and prior coverage terminating immediately before the *effective date* of this agreement furnishes benefits for the hospitalization after the termination of prior coverage, then services and benefits will not be covered under this agreement for that *member* until the *member* is discharged from the *hospital* or benefits under the prior coverage are exhausted, whichever is earlier. “Discharge” means a formal release of a *member* from an *inpatient hospital* stay when the need for continued care at an *inpatient hospital* has concluded. Transfers from one *inpatient hospital* to another shall not be considered a discharge.

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

PREMIUMS

Premium Payment

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

Grace Period

Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 60-calendar day grace period and will be granted for the payment of each premium falling due after the first premium is received. 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. We will notify the *member*, as well as providers, of the possibility of denied claims when the *member* is in the grace period.

Third-Party Payment of Premiums or Cost Sharing

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

1. Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
2. Indian tribes, tribal organizations or urban Indian organizations;
3. State and Federal Government programs;
4. An employer for an employee under an Individual Coverage Health Reimbursement Account (ICHRA) or Qualified Small Employer Health Reimbursement Account (QSEHRA) plan;
5. Family members;
6. Certain tax-exempt organizations, 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 remains due.

Reinstatement

If you have coverage purchased outside the Health Insurance Marketplace, and your *contract* lapses due to nonpayment of premium, it may be reinstated provided:

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

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

Premium accepted for reinstatement may be applied to a period for which premium had not been paid. The period for which back premium may be required will not begin more than 60 calendar days before the date of reinstatement.

The *Rescissions* provision will apply to statements made on the reinstatement application, based on the date of reinstatement.

In all other respects, you and we will have the same rights as before your *contract* lapsed.

Misstatement of Age

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

Change or Misstatement of Residence

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

Health Savings Account (HSA)

A Health Savings Account (HSA) is a special tax-exempt custodial account or trust owned by a *member* where contributions to the account may be used to pay for current and future qualified medical expenses. Please refer to your *Schedule of Benefits* to see if the plan you are enrolled in has an HSA. For *members* enrolled in an HSA compatible plan, the following terms apply.

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

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

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.

UTILIZATION MANAGEMENT

Prior Authorization Required

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

1. Wish to receive a service or supply from a *non-network provider*;
2. Are admitted into a *network facility* by a *non-network provider*; or
3. Are requesting a non-covered service.

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

It is recommended that all services be provided by *network providers*. If you receive services from a *non-network provider*, or services that are not covered, and you do so without first obtaining *prior authorization*, you may be liable for all expenses.

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

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

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

1. Non-emergency *health care services* provided by *non-network providers* ;
2. Reconstructive procedures;
3. Diagnostic Tests such as specialized labs, procedures and high technology imaging;
4. Injectable drugs and medications;
5. *Inpatient health care services*;
6. Specific *surgical procedures*;
7. Nutritional supplements;
8. Pain management services; and
9. Transplant services.

Authorization requests or notification of admission (medical and *behavioral health*) can be submitted by your provider electronically or via telephone, eFax, or provider web portal. Although not required, submitting requests within the recommended timeframes below will allow for timely review of *prior authorization* requests:

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. At least five calendar days prior to the start of *home health care* except those *members* needing *home health care* after *hospital* discharge.

Notification of an admission for emergent/urgent *inpatient* medical, *mental health disorder*, or *substance use disorder* treatment must be received within 24 hours.

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.

After an *authorization* request 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 the lesser of one working day and 24 hours of receipt of the request.
2. For all other urgent *concurrent reviews*, within the lesser of one working day and 72 hours of receipt of the request.
3. For non-urgent pre-service requests regarding proposed admission, procedure or service, within 36 hours, which shall include one business day of obtaining all necessary information.
4. Lesser of 36 hours including one working day of receipt of all necessary information and 72 hours from receipt of request.
5. For post-service or *retrospective reviews*, within 30 calendar days from date of receipt of the request.

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

How to Confirm Prior Authorization

To obtain *prior authorization* or to confirm that your 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

Network providers cannot bill you for services for which they fail to obtain *prior authorization* as required. Benefits will not be reduced for failure to comply with *prior authorization* requirements prior to receiving *emergency services*.

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 this *contract*.

Payment for *authorized* services may be denied, and an *authorization* may be rescinded, if:

1. Such *authorization* is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition;
2. The health benefit plan terminates before the *health care services* are provided; or
3. The *member's* coverage under the health benefit plan terminates before the *health care services* are provided.

If all terms and conditions of the *contract* are met and we authorize a proposed admission, treatment, or *covered service* expense by a health care provider based upon the complete and accurate submission of all necessary information relative to an eligible *member*, we shall not retroactively deny, revoke, or restrict this *authorization* within 45 business days if the health care provider renders the *covered service* expense in good faith and pursuant to the *authorization*.

Notice of Prior Authorization

If a *prior authorization* request is approved, the provider will be informed of the approval by telephone or electronically within 24 hours of making the decision. The *member* will be informed within two business days of the decision being made and written or electronic confirmation of the telephone notification will be provided to the *member* and the provider within two business days of making the adverse determination.

A notice of *prior authorization* includes:

1. The number of certified days of *hospital* confinement;
2. The medical diagnosis, and if applicable, the *surgical procedure* that was certified;
3. Instructions for a *physician* to request additional days of *hospital* confinement (if necessary); and
4. Instructions regarding questions about the *authorization* process.

Notice of Adverse Determination

If treatment is not medically appropriate and *medically necessary*, the provider will be informed of the adverse determination by telephone within twenty-four hours of making the adverse determination, and written or electronic confirmation of the telephone notification will be provided to the *member* and the provider within one business day of making the adverse determination.

The written notification of an adverse determination will include the principal reason or reasons for the determination, including the clinical rationale, and the instructions for initiating an *appeal* or reconsideration of the determination. We will provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to the health care provider and to any party who received notice of the adverse determination.

If a *member* decides to receive non-certified medical treatment, then no benefits are paid. The *member* may elect to file an *appeal* with us. At all times, the final decision for actual medical treatment to be provided is the right and responsibility of the *member* and the *physician*.

Initial Concurrent Review Determinations

For *concurrent review* determinations, a determination will be made within one business day of obtaining all necessary information. In the case of a determination to certify an extended stay or additional services, the provider rendering the service will be notified by telephone within one business day of making the *authorization* and written or electronic confirmation of the telephone notification will be provided to the *member* and the provider within one business day after the telephone notification. The notification will include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

In the case of an adverse determination, the provider rendering the service will be notified by telephone within twenty-four hours of making the *authorization* and written or electronic confirmation of the telephone notification will be provided to the *member* and the provider within one business day after the telephone notification. In any case, services will be continued without liability to the *member* until the *member* has been notified of a determination.

Ongoing Continued Stay Concurrent Care Decisions

Reduction or termination of ongoing plan of treatment: If we have approved an ongoing plan or course of treatment that will continue over a period of time or a certain number of treatments and we notify you that we have decided to reduce or terminate the treatment, we will give you notice of that decision allowing sufficient time to *appeal* the determination and to receive a decision from us before any interruption of care occurs.

Request to extend ongoing treatment: If you have received approval for an ongoing treatment and wish to extend the treatment beyond what has already been approved, we will consider your *appeal* as a request for urgent care. If you request an extension of treatment at least 24 hours before the end of the treatment period, we must notify you soon as possible but no later than 24 hours after receipt of the claim.

An *appeal* of this decision is conducted according to the urgent care *appeals* procedures.

Concurrent urgent care and extension of treatment: Under the concurrent care provisions, any request that involves both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved by us must be decided as soon as possible, taking into account the medical urgencies, and notification must be provided to the *claimant* within 24 hours after receipt of the claim, provided the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Non-urgent request to extend course of treatment or number of treatments: If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by us does not involve urgent care, the request may be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, e.g., as a *pre-service claim* or a *post-service claim*.

If the request is made less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, we may treat the request as a claim involving urgent care and make a decision in accordance with the urgent care claim timeframes, e.g., as soon as possible, taking into account the medical emergencies, but no later than 72 hours after receipt.

Reconsideration of Determination

In a case involving an initial determination or a *concurrent review* determination, the provider rendering the service may request on behalf of the *member* a reconsideration of an adverse determination by the reviewer making the adverse determination. The reconsideration will occur within one business day of the receipt of the request and will be conducted between the provider rendering the service and the reviewer who made the adverse determination, or a clinical peer designated by the reviewer if the reviewer who made the adverse determination is not available within one business day. If the reconsideration process does not resolve the difference of opinion, the adverse determination may be *appealed* by the *member* or the provider on behalf of the *member*. Reconsideration is not a prerequisite to a standard *appeal* or an expedited *appeal* of an adverse determination.

Notification

It is your responsibility to notify us and arrange for the release of necessary medical information from your *physician* to the *utilization review* organization. You may also arrange for the *hospital* or your *physician* to notify the *utilization review* organization; however, if for any reason your *physician* or *hospital* fails to cooperate, the penalty applies as described in the “Failure to Obtain Prior Authorization” provision of this section.

Notification is required for all *hospital* confinements, psychiatric care, *outpatient* surgeries, major diagnostic tests, *home health care*, *extended care facility* confinements, *hospice* services, *rehabilitation facility* confinements, skilled nursing facilities and transplants. Notification **MUST** take place at least two weeks prior to the scheduled confinement, treatment or service.

Services from Non- Network Providers

Except for emergency medical services, 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 a *prior authorization* for you to obtain the service 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 receive services from a *non-network provider*. Otherwise, you will be responsible for all charges incurred.

COST SHARING FEATURES

Cost Sharing Features

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

When you, or a covered dependent, 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 service expenses*. Each claim received will be processed separately according to the cost share as outlined in the *contract* and in your *Schedule of Benefits*.

Deductible

The *deductible amount* means the amount of *covered service expenses* that must be paid by all *members* before any benefits are payable. If on a family plan, if one *member* of the family meets his or her *deductible*, benefits for that *member* will be paid. The *deductible amount* does not include any *copayment amount* or *coinsurance amount*. Not all *covered service expenses* are subject to the *deductible amount*. See your *Schedule of Benefits* for more details.

If you are a covered *member* in a family of two or more *members*, you will satisfy your *deductible amount* when you satisfy your individual *deductible amount* or your family satisfies the family *deductible amount* for the *calendar year*.

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

Copayments

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

Coinsurance Percentage

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

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 *eligible service expenses* for that individual. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket amount*. Both the individual and the family *maximum out-of-pocket amounts* are shown in the *Schedule of Benefits*.

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

If you are a covered *member* in a family of two or more *members*, you will satisfy your maximum out-of-pocket when either you satisfy your individual maximum out-of-pocket, or when your family satisfies the family maximum out-of-pocket for the *calendar year*.

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

The amount payable will be subject to:

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

Please refer to your *Schedule of Benefits* for *coinsurance amounts*, *copayment amounts*, and other limitations.

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 *billed amount* for a service. This is known as *balance billing*. This amount is likely more than *network* costs for the same service and might not count toward your annual *maximum out-of-pocket amount* limit.

However, you are not responsible for *balance billing* when *balance billing protections* apply to *covered services*.

ACCESS TO CARE

Primary Care Physician (PCP)

You may designate a *PCP* for each *member*. You may select any *network PCP* who is accepting new patients. 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 *physician* types:

1. Family practitioners,
2. General practitioners,
3. Internal medicine,
4. Nurse practitioners*,
5. *Physician* assistants,
6. Obstetricians/gynecologists, and
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 physicians*. See your *Schedule of Benefits* for more information.

You may obtain a list of *network PCPs* at our website and accessing the "Find a Doctor" page or by calling the telephone number shown on the front page of this *contract*.

NOTE: You may obtain services from a *network provider* even if you have not previously selected a *PCP*.

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

Contacting Your Primary Care Physician (PCP)

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

Should you need care outside of your *PCP's* office hours, you should call your *PCP's* office for information on receiving after hours care in your area. If you have an urgent medical problem or question or cannot reach your *PCP* during normal office hours, call our 24/7 nurse advice line at 1-833-543-3145 (TTY 711). A licensed nurse is always available and ready to answer your health questions. If you are experiencing an *emergency condition*, call 911 or for a *behavioral health emergency condition*, call 988 or go to the nearest emergency room.

Coverage under Other Contract Provisions

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

Network Availability

The *network* is subject to change. The most current *network* may be found online at our website or by contacting us at the number shown on your *member* identification card. A *network* 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 *covered services* from *non-network providers* that are not subject to *balance billing protections*, benefits will be calculated in accordance with the terms of this *contract* for *non-network providers*.

Non-Emergency Services

If you are traveling outside of the Ambetter Health *service area* you may be able to access providers in another state if there is an Ambetter plan located in that state. You can locate Ambetter *network providers* outside of Missouri by searching the relevant state and the plan you are enrolled in, on 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 care services when you are outside of our *service area*.

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

Continuity of Care

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

1. Notify the *member* in a timely manner of the termination and their right to elect continued transitional care from the provider;
2. Provide the *member* with an opportunity to notify us of the *member's* need for transitional care; and

3. Permit the *member* to elect to continue receiving their benefits for the course of treatment relating to their status as a *continuing care patient* during the period beginning on the date the notice described in (1) is provided and ending on the earlier of:
 - a. 90 calendar days after the notice described in (1) is provided; or
 - b. The date on which such *member* is no longer a *continuing care patient* with respect to 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 new technology, medical procedures, drugs, devices, and applications of existing technology.

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

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

Preferred Partnership

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

Hospital Based Providers

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

MEDICAL EXPENSE BENEFITS

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

The plan provides coverage for *health care services* for a *member* and/or dependents. Some services require *prior authorization*.

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

All *covered services* are subject to conditions, exclusions, limitations, terms and provision of this *contract*. *Covered services* must be *medically necessary* and not *experimental or investigational*. Coverage is limited to Essential Health Benefits and other benefits as required under *applicable laws*. Services that are not Essential Health Benefits and are not otherwise required to be covered under *applicable laws*, are not covered under this *contract*.

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. Cognitive communication therapy,
3. Neurocognitive therapy and *rehabilitation*,
4. Neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment,
5. Neurofeedback therapy,
6. Remediation required for and related to treatment of an acquired brain *injury*,
7. Post-acute transition services and community reintegration services, including *outpatient* day treatment services, or any other post-acute treatment services are covered, if such services are necessary as a result of and related to an acquired brain *injury*.

Treatment for an *acquired brain injury* may be provided at a *hospital*, an acute or post-acute *rehabilitation hospital*, a *skilled nursing facility* or an approved *facility* where *covered services* are provided. Treatment goals for services may include the maintenance of functioning. Or the prevention

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

To ensure that appropriate post-acute care treatment is provided, this plan includes coverage for expenses related to periodic reevaluation of the care of a *member* who has incurred an *acquired brain injury*, has been unresponsive to treatment, is medically stable, and is expected, with the provision of these services and support, to be able to return to a community-based setting rather than reside in a *facility* setting.

Acupuncture Services

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

Ambulance Service Benefits

Air Ambulance Service Benefits

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

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

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

Limitations: Benefits for air ambulance services are limited to:

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

Exclusions:

No benefits will be paid for:

1. Air ambulance services covered by a local governmental or municipal body, unless otherwise required by *applicable 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, excluding air ambulances (for example, commercial flights).

Ambulance Service Benefits (Ground and Water)

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

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

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

Exclusions:

No benefits will be paid for:

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

Autism Spectrum Disorder and Development/Physical Disabilities Expense Benefit

For purposes of this section, the following definitions will apply:

- 1. Autism service provider means:
 - a. Any person, entity, or group that provides diagnostic or treatment services for autism spectrum disorder who is licensed or certified by the state of Missouri; or

- b. Any person who is licensed under chapter 337 as a board-certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board-certified behavior analyst.

Developmental or physical disability is a severe chronic disability that:

1. Is attributable to cerebral palsy, epilepsy, or any other condition other than mental *illness* or *autism spectrum disorder* which results in impairment of general intellectual functioning or adaptive behavior and requires treatment or services;
2. Manifests before the individual reaches age nineteen;
3. Is likely to continue indefinitely; and
 - a. Results in substantial functional limitations in three or more of the following areas of major life activities:
 - i. Self-care;
 - ii. Understanding and use of language;
 - iii. Learning;
 - iv. Mobility;
 - v. Self-direction; or
 - vi. Capacity for independent living.

Diagnosis means *medically necessary* assessments, evaluations, or tests in order to diagnose whether an individual has an *autism spectrum disorder* or a developmental or physical disability.

Habilitative or rehabilitative care means professional, counseling, and guidance services and treatment programs, including *applied behavior analysis* (ABA) therapy for those diagnosed with *autism spectrum disorder*, that are necessary to develop the functioning of an individual.

Line therapist is an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment plan, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst.

Pharmacy care means medications used to address symptoms of an *autism spectrum disorder* or a developmental or physical disability prescribed by a licensed *physician*, and any health-related services deemed *medically necessary* to determine the need or effectiveness of the medications only to the extent that such medications are included in the *member's* health benefit plan.

Psychiatric care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Psychological care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

Therapeutic care means services provided by licensed speech therapists, occupational therapists, or physical therapists.

Treatment is care prescribed or ordered for an individual diagnosed with an *autism spectrum disorder* by a licensed *physician* or licensed psychologist, or for an individual diagnosed with a developmental or physical disability by a licensed *physician* or licensed psychologist, including equipment *medically necessary* for such care, pursuant to the powers granted under such licensed *physician's* or licensed psychologist's license, including, but not limited to:

1. Psychiatric care;
2. Psychological care;
3. Habilitative or rehabilitative care, including *applied behavior analysis* therapy for those diagnosed with *autism spectrum disorder*;
4. Therapeutic care; and
5. Pharmacy care.

Coverage provided under this section for *autism spectrum disorder* or developmental or physical disabilities is limited to *medically necessary* treatment that is ordered by the *member's* treating licensed *physician* or licensed psychologist, pursuant to the powers granted under such licensed *physician's* or licensed psychologist's license, in accordance with a treatment plan.

The treatment plan, upon request by the health benefit plan or health carrier, shall include all elements necessary for the health benefit plan or health carrier to pay claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and goals.

Except for *inpatient* services, if an individual is receiving treatment for an *autism spectrum disorder* or developmental or physical disability, a health carrier shall have the right to review the treatment plan not more than once every six months unless the health carrier and the individual's treating *physician* or psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall only apply to a particular individual receiving *applied behavior analysis* therapy and shall not apply to all individuals receiving *applied behavior analysis* from that autism service provider, *physician*, or psychologist. The cost of obtaining any review or treatment plan shall be borne by the health benefit plan or health carrier, as applicable.

1. Upon request by us, a provider of treatment for *autism spectrum disorder* shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is *medically necessary* and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.
2. When making a determination of medical necessity for a treatment modality for *autism spectrum disorder*, we will make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or *illnesses* covered under this *contract*, including an *appeals* process. During the *appeals* process, any challenge to medical necessity must be viewed as reasonable only if the review includes a *physician* with expertise in the most current and effective treatment modalities for *autism spectrum disorder*. Coverage for *medically necessary* early intervention services must be delivered by certified early intervention specialists.
3. *Habilitation* and *rehabilitation* services, for *members* with a diagnosis of *autism spectrum disorder*, shall include *applied behavior analysis* that is intended to develop, maintain, and restore the functioning of an individual. For physical therapy, speech therapy, or occupational therapy, there is no visit limit when used for the treatment of *autism spectrum disorder*.

Generally recognized services prescribed in relation to *autism spectrum disorder* by a *physician* or *behavioral health* practitioner in a treatment plan recommended by that *physician* or *behavioral health* practitioner.

For purposes of this section, generally recognized services may include services such as:

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

No limitation exists within the benefits for *applied behavior analysis* services. These services are subject to *prior authorization* to determine medical necessity. If multiple services are provided on the same day by different providers, a separate *copayment* and/or coinsurance will apply to each 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 better understand and manage your health conditions, coordinate services and locate community resources.

Your care manager will work with you and your doctor to help you get the care you need. If you have a severe medical condition, your care manager will work with you, your *PCP* and other providers to develop a care plan that meets your needs and your caregiver's needs. If you think you could benefit from our *care management* program, please call Member Services.

Chiropractic Services

We cover *medically necessary* chiropractic care provided on an *outpatient* basis. See the *Schedule of Benefits* for applicable cost share and limits.

Clinical Trial Coverage

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

1. Drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition,
2. Reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial and,

3. All items and services that are otherwise generally available to a *qualified individual* that are provided in the clinical trial except:
 - 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 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 the *member* is enrolled in the clinical trial. This section shall not apply to *members* who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

Clinical trials can be approved if they are approved or funded by one of the following:

1. One of the National Institutes of Health (NIH),
2. The Centers for Disease Control and Prevention,
3. The Agency for Health Care Research and Quality,
4. The Centers for Medicare & Medicaid Services,
5. A cooperative group or center of any of the entities listed above or the Department of Defense or the Department of Veteran Affairs,
6. The FDA in the form of an investigational new drug application,
7. The study or investigation is a drug trial that is exempt from having such an investigational new drug application,
8. The federal Departments of Veterans' Affairs, Defense, or Energy,
9. 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
10. 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. A *qualified individual* must be eligible to participate in the clinical trial, and either (a) have a referral from a doctor stating that the clinical trial would be appropriate for the purposes of prevention, early detection, or treatment of cancer or a life-threatening disease or condition; or (b) the individual must provide medical and scientific information establishing that their participation in the clinical trial would serve the purposes of prevention, early detection, or treatment of cancer or a life-threatening disease or condition.

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

The coverage required by this section is subject to the standard *contract* provisions applicable to other benefits, including *deductible* and coinsurance. Participation in clinical trials is subject to *prior authorization* requirements as outlined in this *contract*.

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.

Covered service expenses include, but are not limited to:

1. Examinations including podiatric examinations;
2. Laboratory and radiological diagnostic testing;
3. Self-management equipment, and supplies such as urine and/or ketone strips,
4. 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*.

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

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

Dialysis Services

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

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

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

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

1. The equipment, supply or appliance is worn out or no longer functions;
2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by 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. and;
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; and
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 & wraps, gloves, suction catheters, surgical sponges, hypodermic needles, syringes, and applicators. The supplies are subject to the *member's deductible, copayment, and/or coinsurance amounts*.

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. Examples include but are not limited to wheelchairs, crutches, *hospital* beds, and oxygen equipment. 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.

Durable medical equipment and supplies are subject to *prior authorization* as outlined in this *contract*. Please see your Schedule of Benefit for benefit levels or additional limits.

Covered services may include, but are not limited to:

1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for IV fluids and medicine.
5. Glucometer.
6. Tracheotomy tube.
7. Cardiac, neonatal and sleep apnea monitors.
8. Augmentive communication devices are covered when we approve based on the *member's* condition.
9. Rental of one Continuous Passive Motion (CPM) machine per *member* following a covered joint *surgery*.
10. Mastectomy bras, four per year if the *member* has undergone a covered mastectomy.
11. Blood Pressure monitors for pregnant or postpartum *members*. Including *member* education, and training services of the set up and use of the home blood pressure monitoring device.

Exclusions:

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

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

Medical and Surgical Supplies

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

Covered services may include, but are not limited to:

1. Allergy serum extracts.
2. Chem strips, glucometer, lancets.
3. Clinitest.
4. Needles/syringes.

5. Ostomy bags and supplies except charges such as those made by a pharmacy for purposes of a fitting are not *covered services*.

Exclusions:

Non-covered services include but are not limited to:

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

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. We cover *medically necessary* corrective footwear. *Prior authorization* may be required.

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.
13. For *medically necessary* foot orthotics, *prior authorization* may be required.

Orthotic devices may be replaced when *medically necessary* and when a device is damaged beyond repair; *prior authorization* may apply.

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 Supplies provision above).

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. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per benefit period, as required by the Women's Health and Cancer Rights Act. Maximums for *prosthetic devices*, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are *covered services*. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract *surgery* or *injury*; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of *surgery* are not considered contact lenses and are not considered the first lens following *surgery*. If the *injury* is to one eye or if cataracts are removed from only one eye and the *member* selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Cochlear implant and Bone Anchored Hearing Aids.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (not to exceed one per *calendar year*) when purchased through a *network provider*.

Exclusions:

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

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

Emergency Services

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

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

Family Planning and Contraception

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

1. The full range of contraceptives currently identified by the U.S. Food and Drug Administration (FDA), including:
 - a. Sterilization *surgery* for women,
 - b. Implantable rods,
 - c. Copper intrauterine devices,
 - d. Intrauterine devices with progestin (all durations and doses),
 - e. Injectable contraceptives,
 - f. Oral contraceptives (combined pill),
 - g. Oral contraceptives (progestin only),
 - h. Oral contraceptives (extended or continuous use),
 - i. The contraceptive patch,
 - j. Vaginal contraceptive rings,
 - k. Diaphragms,
 - l. Contraceptive sponges,
 - m. Cervical caps,
 - n. Condoms,
 - o. Spermicides,

- p. Emergency contraception (levonorgestrel), and
 - q. Emergency contraception (ulipristal acetate).
2. Coverage is also available for any additional contraceptives approved, granted, or cleared by the FDA (if the patient and the patient's attending provider have determined it to be medically appropriate.).
 3. Contraceptive care, such as: screening, education, provision of contraception, counseling and follow-up care (e.g., management, evaluation and changes, including the removal, continuation and discontinuation of contraceptives).
 4. Instruction in fertility awareness-based methods, including lactation amenorrhea.

For prescription contraceptive drugs, a 12-month supply is covered.

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.

First Steps Coverage

Covered service expenses include early intervention services described in this section that are delivered by early intervention specialists who are *health care professionals* licensed by the state of Missouri and acting within the scope of their professions for children from birth to age three identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq.

Such coverage shall be limited to three thousand dollars for each covered child per policy per *calendar year*, with a maximum of nine thousand dollars per child.

Early intervention services means *medically necessary* speech and language therapy, occupational therapy, physical therapy, and assistive technology devices for children from birth to age three who are identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq. Early intervention services shall include services under an active individualized family service plan that enhance functional ability without effecting a cure. An individualized family service plan is a written plan for providing early intervention services to an *eligible child* and the child's family that is adopted in accordance with 20 U.S.C. Section 1436. The Part C early intervention system, on behalf of its contracted regional Part C early intervention system centers and providers, shall be considered the rendering provider of services for purposes of this section.

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits

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

1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must be determined *medically necessary*.
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital, rehabilitation facility, or extended care facility* for:
 - a. Daily room and board and nursing services;
 - b. Diagnostic testing; and
 - c. Drugs and medicines that are prescribed by a *physician*, filled by a licensed pharmacist, and approved by the United States Food and Drug Administration (FDA).
4. *Covered service expenses* for non-provider *facility* services are limited to charges incurred for the professional services of *rehabilitation* licensed practitioners.
5. Coverage for a *skilled nursing facility* and *inpatient rehabilitation* is subject to a *calendar year* day limit, as listed in the *Schedule of Benefits*.
6. *Outpatient habilitation* services are subject to a *calendar year* visit limit, as listed in the *Schedule of Benefits* for occupational therapy and physical therapy. There is not a visit limit for speech therapy or any services provided for a *substance use disorder* or mental health diagnosis, including *autism spectrum disorder*.
7. *Outpatient rehabilitation* services are subject to a *calendar year* visit limit, as listed in the *Schedule of Benefits* for occupational therapy and physical therapy. There is not a visit limit for speech therapy or any services provided for a *substance use disorder* or mental health diagnosis, including *autism spectrum disorder*.
8. Coverage includes cardiac and pulmonary *rehabilitation*.

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

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

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

Definition:

As used in this provision, "*provider facility*" means a *hospital, rehabilitation facility, or extended care facility*.

Hearing and Communicative Disorders

Necessary care and treatment shall include services to identify, assess, diagnose and consult about the need for treatment and to evaluate and monitor the effectiveness of treatment whether by instrumental, perceptual or standard procedures as well as the provision of treatment for any of the previously mentioned communicative disorders. These services shall include, but not be limited to:

1. Diagnostic and extended evaluation of hearing, which may include pure tone air conduction thresholds, speech thresholds, bone conduction thresholds, prediction of *hearing loss* from acoustic reflex, reflex eliciting auditory test, communication handicap inventories, word/sentence recognition tests and evoked potential monitoring and testing;
2. Determining range, nature and degree of hearing function related to a patient's auditory efficiency;
3. Comprehensive behavioral evaluation for sensorineural site which includes advanced acoustic reflex tests, tests of auditory adaptation, tests of frequency discrimination and tests of intensity discrimination;
4. Testing, adjusting and evaluating auditory *prosthetic devices* which may include sound field tests, such as aided word/sentence recognition, real ear measures, warble tone thresholds, narrow band noise thresholds, and comfortable and uncomfortable loudness levels while wearing an auditory prosthesis;
5. Differentiation between organic and nonorganic hearing disabilities through evaluation of total response pattern and use of acoustic tests;
6. Planning, directing, conducting or participating in conservation, habilitative and rehabilitative programs including hearing aid selection and orientation, counseling, guidance, auditory training, speech reading, language *habilitation* and speech conservation;
7. Coordinating and consulting with educational, medical and other professional groups, and with patients and their families;
8. Diagnosing and evaluating speech and language competencies of individuals, including assessment of speech and language skills as related to educational, medical, developmental, social and psychological factors;
9. The services enumerated in paragraphs (2)(B)1.-8 shall be designed to evaluate and treat individuals to develop or utilize speech, language and other communicative skills to the maximum extent possible to remedy any *loss* or impairment for which services are being provided. However, nothing in this rule shall be construed to require services to improve public speaking, care of the professional voice or accent reduction;
10. Cognitive training secondary to open or closed head *injury*, regardless of cause;
11. Assisting individuals with voice disorders to develop proper control of the vocal and respiratory systems for correct voice production;
12. Evaluating and treating children with delayed or impaired speech or language disorders;
13. Determining the need for augmentative/prosthetic communication systems whether or not that system or that device replaces a body part. These systems or devices may include, but are not limited to, sign language, gesture systems, communication boards, electronic automated devices, mechanical devices, a laryngeal prosthesis, palatal prosthesis and synthetic voice systems;

14. Planning, directing, or conducting habilitative and rehabilitative treatment programs to restore or provide communicative efficiency to individuals with communication problems of organic and nonorganic etiology, such as partial to total glossectomy, partial to total laryngectomy, or both;
15. Other *covered services* shall mean any other *medically necessary* medical or *health care services*, or both, for which coverage is provided whether or not for acute conditions, provided while a patient in a *hospital*, or provided by or in a *rehabilitation center*, *skilled nursing facility*, clinic, home health agency or community-based program. This means that limitations on coverage may not be specific to speech, language and hearing disorders or for services rendered by speech language pathologists and audiologists; and
16. The communicative disorders generally treated by speech/language pathologists and audiologists shall include, but not be limited to, aphasia; motor speech disorders; delayed speech or language ability; total or partial speech or language *loss* or deficit; swallowing disorders; total or partial *hearing loss* or deficit; disorders of verbal and written language, articulation, voice, fluency, mastication, deglutition, cognition, auditory or visual processing and memory, and interactive communications; and disorders of air conduction, bone conduction, word/sentence recognition and acoustic impedance.

Hearing Aids

One pair of hearing aids is covered each year, regardless of *member's* age. Expenses for these services are covered if *medically necessary* and may be subject to *prior authorization*. Please see your *Schedule of benefits* for more information regarding services that require *prior authorization*.

Home Health Care Service Expense Benefits

Covered service expenses and supplies for *home health care* are covered when your *physician* indicates you are not able to travel for appointments in a medical office. *Home health care* services and benefits are subject to *prior authorization* requirements as outlined in this *contract*. Coverage is provided for *medically necessary network* care provided at the *member's* home and includes the following:

1. *Home health aide services*;
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care*;
3. 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;
4. Intravenous medication and pain medication;
5. Hemodialysis, and for the processing and administration of blood or blood components;
6. *Medically necessary medical supplies*; and
7. Rental of *medically necessary durable medical equipment*.

Intravenous medication and pain medication are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay. We may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider we authorize before the purchase.

Limitations:

See 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 Expense Benefits.

Hospice Care Service Expense Benefits

This provision only applies to a *terminally ill member* receiving *medically necessary* care under a *hospice* care program or in a home setting. *Respite care* is covered on an *inpatient* or home basis to allow temporary relief to family members from the duties of caring for a *member* 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. Benefits for *hospice inpatient*, home and *outpatient* care is subject to *prior authorization* as outlined in this *contract*. See your *Schedule of Benefits* for coverage limits.

The list of *covered service expenses* is 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*.

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

Exclusions and Limitations:

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

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

Hospital Benefits

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

1. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
2. 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 *injury* or *illness*, even if confinement is not required. See your *Schedule of Benefits* for limitations.

Infertility Services

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

Long Term Acute Care

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

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

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

- a. Primary condition and at least two other actively treated co-morbid conditions that require monitoring and treatment,
 - b. Common conditions include metabolic disorders, stroke, heart failure, renal insufficiency, necrotizing pancreatitis, emphysema (COPD), peripheral vascular disease, and malignant/end-stage disease.
4. *Rehabilitation*:
- a. Care needs cannot be met in a *rehabilitation* or *skilled nursing facility*,
 - b. Patient has a comorbidity requiring acute care,
 - c. Patient is able to participate in a goal-oriented *rehabilitation* plan of care,
 - d. Common conditions include CNS conditions with functional limitations, debilitation, amputation, cardiac disease, orthopedic *surgery*.
5. Mechanical ventilator support:
- a. Failed weaning attempts at an acute care *facility*,
 - b. Patient has received mechanical ventilation for 21 consecutive calendar days for 6 hours or more per day,
 - c. Ventilator management required at least every 4 hours as well as appropriate diagnostic services and assessments,
 - d. Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions,
 - e. Patient is hemodynamically stable and not dependent on vasopressors,
 - f. Respiratory status is stable with maximum PEEP requirement 10 cm H₂O, and FiO₂ 60% or less with O₂ saturation at least 90%,
 - g. Common conditions include complications of acute lung *injury*, disorders of the central nervous and neuromuscular systems, and cardiovascular, respiratory, and pleural/chest wall disorders,
 - h. Patient continues to meet the criteria above and does not meet the criteria to be transitioned to alternate level of care.

Low-Protein Food Products for Treating Inherited Metabolic Diseases

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

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

- 1. Phenylketonuria (PKU),
- 2. Maple Syrup Urine Disease (MSUD),

3. Methylmalonic Acidemia (MMA),
4. Isovaleric Acidemia (IVA),
5. Propionic Acidemia,
6. Glutaric Acidemia,
7. Urea Cycle Defects,
8. Tyrosinemia.

Medical Foods

We cover medical foods and formulas for:

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

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

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

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

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

Lymphedema Benefit

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

Mammography Coverage

"Mammogram" includes low-dose mammography screening, digital mammography and breast tomosynthesis. Low-dose mammography screening means the X-ray examination of the breast using equipment specifically designed and dedicated for mammography, including the X-ray tube, filter, compression device, detector, films, and cassettes, with an average radiation exposure delivery of

less than one rad mid-breast, with two views for each breast, and any fee charged by a radiologist or other *physician* for reading, interpreting or diagnosing based on such X-ray. The term "low-dose mammography screening" shall also include digital mammography and breast tomosynthesis. The term "breast tomosynthesis" shall mean a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

Covered services for a *member* will include mammography screenings that align with United States Preventive Services Task Force (USPSTF) A and B rated guidelines, as well as *applicable laws*, and are covered without cost share when obtained from a *network provider*. 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. **NOTE** (exception): For HSA-compatible plans, the *deductible* cannot be waived for benefits that exceed the federal ACA preventive care requirements.

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 healthcare provider submit the *prior authorization* prior to the delivery, however the *physician* or other health care provider must notify us upon admission. An *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require notification to the health plan.

Duty to Cooperate

We cover maternity care 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 be a *surrogate*, send us written notice using the Notification of Surrogacy form

AmbetterHealth.com/en/ichra/employees/handbooks-forms.html to Ambetter Health Solutions at:

Ambetter Health Solutions
Attn: Mailroom Department
C/o Surrogacy Forms
P.O. Box 5010
Farmington, MO 63640-5010

Newborn Charges

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

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

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

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

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

Maternity coverage of a home birth by a midwife or nurse midwife is limited to low-risk *pregnancy* and may be subject to *prior authorization* requirements.

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

Post-Discharge Care

Post-discharge care may consist of a visit in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a *physician*. The location and schedule of the post-discharge visits shall be determined by the attending *physician*. Services provided by the registered professional nurse or *physician* shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. Any abnormality, in the condition of the mother or the child, observed by the nurse shall be reported to the attending *physician* as medically appropriate.

Newborns' and Mothers' Health Protection Act Statement of Rights

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

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, we may provide benefits for *covered service expenses* incurred for a shorter stay if the

attending provider (e.g., your *physician*, nurse midwife or *physician* assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

Medical and Surgical Expense Benefits

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

1. For *surgery* in a *physician's* office, an *inpatient facility*, an *outpatient facility* or a surgical *facility*, including services and supplies.
2. For *durable medical equipment*, *prosthetic devices*, *orthotic devices* or other *necessary medical supplies* following a medical or *surgical procedure* such as, crutches, orthopedic splints, braces, casts. Please see the Durable Medical Equipment provision of this *contract*.
3. For pre-surgical, and post-surgical procedures and testing, including but not limited to:
 - a. Diagnostic services using radiologic, ultrasonographic, or laboratory services,
 - b. 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,
 - c. Bone density studies,
 - d. Clinical laboratory tests,
 - e. Gastrointestinal laboratory procedures,
 - f. Pulmonary function tests,
 - g. Genetic testing,
 - h. For *medically necessary* genetic or molecular cancer testing, including but not limited to, tumor mutation testing, next generation sequencing, hereditary germline mutation testing, pharmacogenomics testing, whole exome, genome sequencing and biomarker testing.
4. For chemotherapy (including oral chemotherapy), inhalation therapy, infusion therapy, and radiation therapy or treatment in a *hospital* or office setting.
5. For hemodialysis, and the charges by a *hospital* or *facility* for processing and administration of genetic testing, blood or blood components, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for you.
6. For the cost and administration of an anesthesia, oxygen, drugs, medications, and biologicals.
7. For *medically necessary* reconstructive or cosmetic *surgery* including but not limited to:

- a. Reconstructive breast *surgery* charges as a result of a partial or total mastectomy, with no time limit imposed for reconstructive *surgery* as a result of mastectomy. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedema,
 - b. *Reconstructive surgery* for craniofacial abnormalities.
8. For *medically necessary* chiropractic care or manipulative therapy treatment on an *outpatient* basis.
9. 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.
10. Well Childcare examinations, including child health supervision services, based on American Academy of Pediatric Guidelines.
11. For *medically necessary* human organ and tissue transplants.
12. Family Planning for certain professional provider contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices to the extent such services and supplies are legal under *applicable law*.
13. For *medically necessary* allergy testing and treatment including allergy injections and serum.
14. 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.
15. For the treatment of breast cancer by dose-intensive chemotherapy/*autologous bone marrow transplants* or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/*autologous bone marrow transplants* or stem cell transplants.
16. For *medically necessary telehealth services*. *Telehealth services* not provided through *Virtual 24/7 Care* would be subject to the same *cost sharing* as the same *health care services* when delivered to a *member* in person.
17. For cancer screenings, as follows:
 - a. A pelvic examination and pap smear for any non-symptomatic woman who is a *member*, in accordance with the current American Cancer Society guidelines;
 - b. A prostate examination and laboratory tests for cancer for any non-symptomatic man who is a *member*, in accordance with the current American Cancer Society guidelines; and
 - c. A colorectal cancer examination and laboratory tests for cancer for any non-symptomatic *member*, in accordance with the current American Cancer Society guidelines.
18. For respiratory and pulmonary therapy.
19. Services related to diagnosis, treatment and appropriate management of osteoporosis when such services are provided by a person licensed to practice medicine and *surgery* in the state, if the *member* has a condition or medical history for which bone mass measurement is medically indicated.

20. Testing of pregnant women and other *members* for lead poisoning.
21. For *medically necessary* footcare treatment that may require *surgery*; *prior authorization* may be required.
22. 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.
23. 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*.
24. For the following types of *medically necessary* implants and tissue grafts:
 - a. Cornea transplants,
 - b. Artery or vein grafts,
 - c. Heart valve grafts,
 - d. Prosthetic tissue replacement, including joint replacements,
 - e. Implantable prosthetic lenses, in connection with cataracts,
 - f. Skin grafts.
25. 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*.
26. For infertility counseling and planning services when provided by a *network provider* and testing to diagnose infertility.
27. For *surgery* or services related to cochlear implants and bone-anchored hearing aids.
28. For *medically necessary* services for complications arising from medical and surgical conditions.
29. For respiratory, pulmonary, cardiac, physical, occupational and speech therapy services. Please see Habilitation, Rehabilitation and Extended Care Facility Expense Benefits provisions of this *contract*.
30. For dermatology services which are limited to the following: *medically necessary* minor *surgery*, tests and office visits provided by a dermatologist who is a *network provider*.
31. For *medically necessary* biofeedback services.
32. When deemed *medically necessary* by your provider, nutritional counseling is a covered benefit.
33. Newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.
34. For elective sterilization procedures (e.g., vasectomies, tubal ligation). **NOTE:** No cost-share applies, except for HSA-compatible plans.
35. For expenses or services related to immunizations and vaccinations for travel purposes.
36. For administration of *medically necessary* anesthesia by a licensed *medical practitioner*. No time limits will be imposed on the administration of *medically necessary* anesthesia.

37. For *medically necessary* services or treatment for:

- a. A medically verifiable disorder of sexual development; or
- b. *Behavioral health* treatment for gender dysphoria (e.g., psychotherapy).

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 associated charges for *medically necessary* dental care are covered if the *member* requires dental treatment to be rendered under general anesthesia. The indications for general anesthesia, as published in anesthesia and sedation reference manuals of the American Academy of Pediatric Dentistry, and American Dental Association 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, but not limited the following:
 - a. 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.
 - b. Treatment for temporomandibular joint (TMJ) disorder, including removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services.
 - c. Treatment of non-dental lesions, such as removal of tumors and biopsies.
 - d. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
 - e. *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.
 - f. *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.
 - g. *Surgery*, excluding tooth extraction, to treat craniomandibular disorders, or malocclusions.
2. Dental service expenses when a *member* suffers an *injury* that results in damage to the natural teeth, not to include damage resulting from chewing or parafunctional habit.

3. *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.

Medical Vision Services

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

1. Referrals to a specialist *physician* for evaluation and diagnosis of refractive error, including presbyopia.
2. Visual therapy.
3. Low vision services and hardware for adults.
4. Eye examinations required by an employer or as a condition of employment.
5. Radial keratotomy, LASIK, and other refractive eye *surgery*.
6. Services or materials provided because of any workers' compensation law or required by any governmental agency.
7. Orthoptics, vision training, or subnormal vision aids.
8. Non-network care, except when prior authorized.
9. Any vision services, treatment or material not specifically listed as a *covered service*.

Mental Health and Substance Use Disorder Benefits

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

Covered services will be provided on an *inpatient* and *outpatient* basis and include mental health and *substance use disorders*. If you need mental health and/or *substance use disorder* treatment, you may choose any provider participating in our *behavioral health* and *substance use disorder network*. You can search for *network behavioral health* providers by accessing our "Find a Doctor" page at Ambetterhealth.com or by calling Member Services. *Deductible amounts, copayment or coinsurance amounts* and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

Covered services for the diagnosis and *medically necessary* treatment of *mental health disorders* and *substance use disorders*, as defined in this *contract* are included on a non-discriminatory basis for all *members*. Treatment limitations applicable to *mental health disorders* and *substance use disorder* benefits will not be applied more stringently than those placed on coverage for medical and surgical benefits.

When making coverage determinations, our *behavioral health* utilization management staff utilizes established level of care guidelines and medical necessity criteria that are based on *generally accepted standards of medical practice* and take into account legal and regulatory requirements. Our *behavioral health* staff utilize Change Healthcare InterQual criteria for mental health determinations and American Society of Addiction Medicine (ASAM) criteria for *substance use disorder*

determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

Covered services include feeding and eating disorders as defined in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including but not limited to anorexia nervosa, bulimia nervosa, binge eating disorder, and avoidant/restrictive food intake disorder. These are covered as mental health conditions and are eligible for *medically necessary* treatment.

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

Inpatient

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

Outpatient

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

We subclassify our *outpatient* mental health and *substance use disorder* benefits into two categories; office visits and other *outpatient services*.

1. Office visits include individual therapy, group therapy, routine evaluation and management in an office setting, medication monitoring/management, *outpatient* detoxification, nutritional counseling, urgent care and telehealth.

2. Other *outpatient services* include psychological testing, neuropsychological testing, electroconvulsive therapy, *transcranial magnetic stimulation*, applied behavior analysis, medication assisted treatment, intensive *outpatient* programs, partial hospitalization/day treatment (eight hours) and partial hospitalization/half day treatment (four hours), laboratory procedures, and habilitation/*rehabilitation services* (physical therapy, speech therapy, occupational therapy).

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

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.

This health benefit plan requires that all *health care services* be delivered by a participating provider in our *network*. Services rendered by a *non-network provider* are not covered under this plan, except for *emergency services* and two sessions per year to a licensed psychiatrist, licensed psychologist, licensed professional counselor, or a licensed clinical worker for the purpose of diagnosis or assessment of mental health.

NOTE: Please be aware that some services addressed in other sections of this *contract*, may be provided to treat both medical/surgical and *behavioral health* diagnoses. Cost share determinations for such treatment will align with the primary diagnosis code billed (medical/surgical or *behavioral health*). For example, nutritional counseling provided and billed to treat an eating disorder diagnosis will fall under *behavioral health*, while nutritional counseling provided and billed to treat a diagnosis of diabetes will fall under medical/surgical care.

Pediatric Vision Benefits – Children under the age of 19

This plan complies with the pediatric vision benefit requirements as defined by 45 CFR §156.110(b)(3). 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. Eye evaluation including dilation.
2. Standard frames.
3. Prescription lenses:
 - a. Single,
 - b. Bifocal,
 - c. Trifocal,
 - d. Lenticular.
4. Additional lens options (including coating and tints):
 - a. Progressive lenses (standard or premium),
 - b. Intermediate vision lenses,
 - c. Blended segment lenses,

- d. Hi-Index lenses,
 - e. Plastic photosensitive lenses,
 - f. Photochromic glass lenses,
 - g. Glass-grey #3 prescription sunglass lenses,
 - h. Fashion and gradient tinting,
 - i. Ultraviolet protective coating,
 - j. Polarized lenses,
 - k. Scratch resistant coating,
 - l. Anti-reflective coating (standard, premium or ultra),
 - m. Oversized lenses,
 - n. Polycarbonate lenses.
- 5. Contact lens allowance (includes contact lens fitting)
 - 6. Low vision evaluation/aids.

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

Services not covered:

- 1. Deluxe frame/frame upgrade.
- 2. Visual therapy (see medical coverage).
- 3. Two pairs of glasses as a substitute for bifocals.
- 4. LASIK or other refractive *surgery*.
- 5. Replacement eyewear.

Prescription Drug Expense Benefits

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

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

- 1. A *prescription drug*;
- 2. Any drug that, under the *applicable law*, may be dispensed only upon the written prescription of a *physician*;
- 3. Off-label drugs that are:
 - a. Recognized for treatment of the indication in at least one (1) standard reference compendium; or
 - b. Recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

4. Prescribed, oral anticancer medication.

Such *covered service expenses* shall include those for prescribed, orally administered anticancer medications. The *covered service expenses* shall be no less favorable than for intravenously administered or injected cancer medications that are covered as medical benefits under this *contract*.

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

The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her *physician*. If we change our formulary we will provide you with notification of the change electronically, or in writing, upon your request, at least 30 calendar days in advance of the change. If the dosage of a prescription is such that two different manufactured dosage amounts are required, and you pay your *copay* for both dosages, you may submit the claims to us for reimbursement of the additional *copay*.

Prescription Drug Synchronization

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

Formulary or Prescription Drug List

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

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

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the formulary. For the most current formulary or *prescription drug* list or for more information about our pharmacy program, visit [Ambetterhealth.com](https://www.ambetterhealth.com) or call Member Services.

Non-Covered services and Exclusions:

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

1. For *prescription drug* treatment of erectile dysfunction or any enhancement of sexual performance unless such treatment is listed on the formulary.
2. For weight loss *prescription drugs* unless otherwise listed on the formulary.
3. For immunization agents otherwise not required by the Affordable Care Act.
4. For medication that is to be taken by the *member*, in whole or in part, at the place where it is dispensed.
5. For medication received while the *member* is a patient at an institution that has a *facility* for dispensing pharmaceuticals.
6. For a refill dispensed more than 12 months from the date of a *physician's* order.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are listed on the formulary.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For any drug that we identify as therapeutic duplication through the drug *utilization review* program.
11. For more than a 30-calendar day supply when dispensed in any one prescription or refill or for maintenance drugs up to a 90-calendar day supply when dispensed by mail order or a pharmacy that participates in extended day supply network. Specialty drugs and other select drug categories are limited to 30-calendar day supply when dispensed by retail or mail order. Please note that only the 90-calendar day supply may be subject to the discounted *cost sharing*. Mail orders less than 90 calendar days are subject to the standard *cost sharing* amount.
12. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
13. Foreign Prescription Medications, except those associated with an emergency medical condition while you are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this document if obtained in the United States.
14. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventive treatment is related to *member's* vacation during out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
15. For medications used for cosmetic purposes.
16. For infertility drugs unless otherwise listed on the formulary.
17. For any drug related to *surrogate pregnancy*.
18. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.

19. 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.
20. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
21. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status.
22. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
23. Compound drugs unless there is at least one ingredient is an FDA approved drug.
24. Medication refills where a *member* has more than 15 *calendar days'* supply of medication on hand.

Generic Medications

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

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" below for additional details.

Standard Exception Request

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

Expedited Exception Request

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

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

External Exception Request Review

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

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

How to Fill a Prescription

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

If you decide to have your *prescription order* filled at a *network* pharmacy, you can use the Provider Directory to find a pharmacy near you. You can access the provider directory at [Ambetterhealth.com](https://www.ambetterhealth.com) on the Find a Doctor page. You can also call Member Services to help you find a pharmacy. At the pharmacy, you will need to provide the pharmacist with your *prescription order* and your *member* identification card.

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

Under Missouri law you have the right to request a refill of your prescription eye drops regardless of the date when you originally filled your prescription. To exercise this right please speak with your provider or contact Member Services.

Lock-In Program

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

Coverage of Nonopioid Pain Medications

When a prescription nonopioid pain medication is a covered benefit under this *contract*, Ambetter will not require a *member* to first use, fail, or be unable to tolerate an opioid medication before receiving coverage for the covered nonopioid pain medication. Ambetter will not impose utilization management requirements that are more restrictive for a covered nonopioid pain medication than for an opioid medication prescribed for the same condition, except as otherwise permitted by *applicable laws*.

Mail Order Pharmacy/Prescription Drug Delivery

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

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.

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.

Preventive Care Expense Benefits

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

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

Preventive care benefits obtained from a *network provider* are covered without *member* cost share (i.e., covered in full without *deductible*, coinsurance or *copayment*). For current information regarding available preventive care benefits, please access the Federal Government's website at:

www.healthcare.gov/center/regulations/prevention.html.

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

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

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

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

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

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

Notification

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

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

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

Second Medical Opinion

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

1. Whenever a minor *surgical procedure* is recommended to confirm the need for the procedure;
2. Whenever a serious *injury* or *illness* exists;
3. Whenever you find that you are not responding to the current treatment plan in a satisfactory manner; or
4. If you are newly diagnosed with cancer, you have the right to a referral for a second opinion by a board-certified specialist in the specific cancer diagnosis area prior to beginning treatment. If no such specialist is available in-network, a referral will be made to a non-network specialist.

If requested, the second opinion consultation is to be provided by a *physician* of the *member's* choice. The *member* may select a *network provider* listed in the Provider Directory. If a *member* chooses a *network provider*, he or she will only be responsible for the applicable *cost sharing* for the consultation. Any lab tests and/or diagnostic and therapeutic services are subject to the additional *cost sharing*. If the *member* chooses a *non-network provider*, that provider may request a *prior authorization*, but approval is not guaranteed.

Sleep Studies

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

Transplant Expense Benefits

Covered Services and Supplies for Transplant Service Expenses:

Transplants are a *covered service* when a *member* is accepted as a transplant candidate and obtains *prior authorization* in accordance with this *contract*. *Prior authorization* must be obtained through the "Center of Excellence", a *network facility*, or in a non-network *facility* approved by us when there is no network adequacy, before an evaluation for a transplant. We may require additional information such as testing and/or treatment before determining medical necessity for the transplant benefit.

Authorization must be obtained prior to performing any related services to the transplant *surgery*.

Transplant services must meet medical criteria as set by Medical Management policy.

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

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

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

1. Pre-transplant evaluation.
2. Pre-transplant harvesting of the organ from the donor.
3. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
4. Including *outpatient covered services* related to the transplant *surgery*; pre-transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection, and other immunosuppressant drug therapy, etc. Also included is the cost for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. At the time of testing, the *member* must complete and sign an informed consent form authorizing the results of the test to be used for participation in the National Marrow Donor Program, as required by Missouri law.
5. Pre-transplant stabilization, meaning an *inpatient* stay to medically *stabilize* a *member* to prepare for a later transplant, whether or not the transplant occurs.
6. The transplant itself, including the acquisition cost for the organ or bone marrow when *authorized* through the *Center of Excellence* and services are performed at a 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 AmbetterHealth.com/en/ichra/employees/handbooks-forms.html.

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

Ancillary "Center of Excellence" Service Benefits

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

1. We will pay for the following services when the *member* is required to travel more than 60 miles from the *residence* to the *Center of Excellence*.
2. We will pay a maximum of \$10,000 per transplant 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 a *member*, donor and/or companion(s) is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.

- c. Maximum reimbursement for mileage is limited to the total miles traveled by the transplant recipient and by the donor and their respective companion(s), to and from their respective homes to the transplant *facility*, plus miles traveled:
 - i. Between the transplant *facility* and local lodging; and
 - ii. Between a transit hub (e.g., airport, train station, bus station) and either the transplant *facility* or local lodging.
- d. Lodging at or near the *Center of Excellence* for any live donor and 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 travel reimbursement transplant travel forms and information at AmbetterHealth.com/en/ichra/employees/handbooks-forms.html.

Non-Covered Services and Exclusions:

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

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the *Center of Excellence*.
4. To keep a donor alive for the transplant operation, except when *authorized* through the *Center of Excellence*.
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
6. Related to transplants unauthorized through the *Center of Excellence* and is not included under this provision as a *medically necessary* transplant.
7. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("FDA") regulation, regardless of whether the trial is subject to FDA oversight.
8. The acquisition cost for the organ or bone marrow, when provided at an unauthorized *facility* or not obtained through the *Center of Excellence*.
9. For any transplant services and/or travel related expenses for the *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, hybrid, and electric cars (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.).

- d. Parking (unless preapproved by Case Management).
- e. Storage rental units.
- f. Temporary housing incurring rent/mortgage payments.
- g. Loss of wages due to time off from work required for transplant for recipient, donor, or companion(s).
- h. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
- i. Moving violation tickets or parking tickets.
- j. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.).
- k. Any services related to pet care, boarding, lodging, food and/or travel expenses.
- l. Expenses for persons other than the transplant recipient, donor or their respective companion(s).
- m. Expenses for lodging when the transplant recipient, donor, or their respective companion(s) are staying with a relative, friend or otherwise have free lodging.
- n. Any expense not supported by a receipt.
- o. Upgrades to first class travel (air, bus, and train).
- p. Personal care items (e.g., shampoo, deodorant, clothes).
- q. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA pre-check, and early check-in boarding fees, extra baggage fees.
- r. Souvenirs (e.g., t-shirts, sweatshirts, toys).
- s. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type.
- t. All other items not described in the *contract* as *eligible service 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 Service Benefits

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

Members are encouraged to contact their *primary care physician* for an appointment before seeking care from another *physician*, but *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 1-833-543-3145 (TTY 711). 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 or by contacting Member Services.

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

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

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

You can access other services in connection with this *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 on *covered services*, with several repayment options to fit their needs. The Ambetter Perks program is offered to all *members*. We are not involved in administering programs; you will communicate directly with any vendors if you choose to participate.

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

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

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*.
2. For any portion of the charges that are in excess of the *eligible service expense*.
3. For weight modification, bariatric *surgery*, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *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 breast reduction or augmentation.
6. For the reversal of elective sterilization procedures.
7. For abortions unless performed to save the life of the *member* and not illegal under *applicable law*.
8. For artificial insemination (AI), assisted reproductive technology (ART) procedures or the diagnostic tests and drugs to support AI or ART procedures.
9. For expenses for television, telephone, or expenses for other persons.
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.

11. For telephone consultations between providers, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
12. For stand-by availability of a *medical practitioner* when no treatment is rendered.
13. For dental service expenses, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, and routine pediatric dental services, except as expressly provided for under Medical Service Benefits.
14. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under this *contract* or is performed to correct a birth defect.
15. For diagnosis or treatment of nicotine addiction, except as otherwise covered as part of preventive care.
16. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Expense Benefits.
17. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
18. For services while confined primarily to receive *rehabilitation*, *custodial care*, educational care, or nursing services (unless expressly provided for in this *contract*).
19. For vocational or recreational therapy, vocational *rehabilitation*, *outpatient* speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
20. 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*.
21. For the treatment of infertility except as expressly provided in this *contract*.
22. For *experimental or investigational* treatment(s) or *unproven services*. The fact that an *experimental or investigational* treatment or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational* treatment or *unproven service* for the treatment of that particular condition.
23. For treatment received outside the United States, except for a medical emergency while traveling for up to a maximum of 180 consecutive calendar days. If travel extends beyond 180 consecutive calendar days, no coverage is provided for medical emergencies for the entire period of travel including the first 180 calendar days.
24. For an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to *applicable law*. If you enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's* workers' compensation claim, this exclusion will still apply unless that denial is *appealed* to the proper governmental agency and the denial is upheld by that agency.
25. For fetal reduction *surgery*.
26. Except as specifically identified as a *covered service* expense under the *contract*, services or expenses for alternative treatments, including acupuncture, aromatherapy, dry needling, 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. For any *injury* sustained while at a *residential treatment facility*.
28. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
29. For the following miscellaneous items: artificial insemination (except where required by federal or state law); blood and blood products; 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*.
30. For court ordered testing or care unless *medically necessary*.
31. For domiciliary care provided in a residential institution, treatment center, halfway house, or school because a *member's* own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
32. For diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
33. For services or supplies eligible for payment under either federal or state programs (except Medicaid). This exclusion applies whether or not you assert your rights to obtain this coverage or payment of these services.
34. For biofeedback.
35. Mental Health Services are excluded:
- a. Evaluation for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless a *network provider* determines such evaluation to be *medically necessary*.
 - b. When ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless a *network provider* determines such services to be *medically necessary*.
 - c. Court-ordered testing and testing for ability, aptitude, intelligence or interest.
 - d. Services which are custodial in nature.
36. For *surrogacy arrangements*. *Health care services*, including supplies and medication to a non-member *surrogate* and any child born as a result except where the child is the adoptive child of a *member* possessing an active *contract* with us and/or the child possesses an active *contract* with us at the time of birth. This exclusion applies to all *health care services*, supplies and medication to the non-member *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 carrier arrangement;
- h. Preimplantation genetic diagnoses relating to a *surrogacy arrangement*; including but not limited to labs, imaging, and diagnostics;
- 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. Pre-counseling, advice on procreation, or consultations related to gestational carriers or donor services;
- l. Any corrective surgeries or laparoscopic procedures for the sole purpose of a *surrogacy arrangement*; or
- m. For any other medical or healthcare services related to the *pregnancy* or preparations of becoming a *surrogate* or donor will not constitute as a covered benefit.

Any and all other *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 at the time of birth.

- 37. For Assertive Community Treatment (ACT).
- 38. For any medicinal and recreational use of cannabis or marijuana.
- 39. For expenses, services, and treatments related to private duty nursing in an *inpatient* location.
- 40. For vehicle installations or modifications which may include but are not limited to adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.
- 41. For all *health care services* obtained at an urgent care *facility* that is a *non-network provider*.
- 42. For expenses or services related to immunizations and vaccinations for occupational purposes.
- 43. For expenses, services, and treatments from a massage therapist to touch and manipulate the muscles and other soft tissues of the body.
- 44. For expenses, services, and treatments from a naprapathic specialist for conditions caused by contracted, injured, spasmed, bruised, and/or otherwise affected myofascial or connective tissue.
- 45. For expenses, services, and treatments from a naturopathic specialist for treatment of prevention, self-healing and use of natural therapies.
- 46. For *injury* or *illness* arising out of, or in the course of, commission of a felony or engagement in an illegal occupation by a *member*.
- 47. For doula services.
- 48. For any specified sex-trait modification procedures, in accordance with federal regulations in 45 CFR § 156.115(d), which include any pharmaceutical or surgical intervention that is provided for the purpose of attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex either by intentionally:

- a. Disrupting or suppressing the normal development of natural biological functions, including primary or secondary sex-based traits; or
- b. Altering an individual's physical appearance or body, including amputating, minimizing or destroying primary or secondary sex-based traits such as the sexual and reproductive organs.

TERMINATION

Termination of Contract

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date of termination that you provide us upon your request of cancellation to us, or, the last day of the month we receive a request from you to terminate this *contract*, or any later date stated in your request will be effective the last day of the requested month.
3. For a covered *eligible child* reaching the limiting age of 26, coverage under this *contract* will terminate at 11:59 p.m. on the last day of the year in which the *eligible child* 26.
4. The date we decline to renew this *contract*, as stated in the Discontinuance provision.
5. The date of your death, if you are the only *member* on this *contract*.
6. The date your eligibility for insurance under this *contract* ceases due to any of the reasons stated in the Eligibility and Enrollment section in this *contract*.
7. The date your eligibility for coverage under this *contract* ceases as determined by us.

If this *contract* is other than an individual coverage only plan (i.e., includes family coverage), it may be continued after your death:

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

This *contract* will be changed to a plan appropriate, as determined by us, to the *member(s)* that continue to be covered under it. Your *spouse* or youngest child will replace you as the primary *member*. A proper adjustment will be made in the premium required for this *contract* to be continued. We will also refund any premium paid and not earned due to your death. The refund will be based on the number of full months that remain to the next premium due date. The refund will be made directly to:

1. The decedent's *spouse* at the time of the decedent's death;
2. The *subscriber* (primary *member*), if the decedent was not married at the time of death and was covered as a dependent;
3. The decedent's estate, if neither (1) nor (2) are applicable. The premium will not be refunded if we are notified of the *member's* death more than one year after the death of the decedent.

Refund upon Cancellation

We will refund any premium paid and not earned due to *contract* termination. You may cancel this *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. If you cancel, we shall promptly return any unearned portion of the premium paid, but in any event shall return the unearned portion of the premium within 20 calendar days. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the *effective date* of the cancellation.

Discontinuance

90-Day Notice: If we discontinue offering all *contracts* issued on this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 90 calendar days prior to the date that we discontinue coverage. You will be offered an option to purchase any other coverage in the individual market we offer in your state at the time of discontinuance of this *contract*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180-Day Notice: If we discontinue offering all individual *contracts* in the individual market in the state where you reside, we will provide a written notice to you and the Director of the Missouri Department of Commerce and 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.

Portability of Coverage

If a person ceases to be a *member* due to the fact that the person no longer meets the definition of *dependent member* under the *contract*, the person will be eligible for continuation of coverage. If elected, we will continue the person's coverage under this *contract* by issuing an individual *contract*. The premium rate applicable to the new *contract* will be determined based on the *residence* of the person continuing coverage. All other terms and conditions of the new *contract*, as applicable to that person, will be the same as this *contract*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new *contract* to the extent satisfied under this *contract* at the time that the continuation of coverage is issued. (If the original coverage contains a family *deductible* which must be met by all *members* combined, only those expenses incurred by the *member* continuing coverage under the new *contract* will be applied toward the satisfaction of the *deductible amount* under the new *contract*.)

Reinstatement

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

Notification Requirements

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

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. Notice given by or on behalf of you at 7711 Carondelet Ave. St. Louis, MO 63105, or to any authorized agent of ours, with information sufficient to identify you, will be deemed notice to us.

Claim Forms

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

Proof of Loss

Written *proof of loss* must be furnished to us in case of claim for *loss* for which this *contract* provides any periodic payment contingent upon continuing *loss* within 90 calendar days after the termination of the period for which the insurer is liable and in case of claim for any other *loss* within 90 calendar days after the date of such *loss*. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. Subject to due written *proof of loss*, all accrued indemnities for *loss* for which this *contract* provides periodic payment will be paid monthly.

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 Medical Claim Form posted at AmbetterHealth.com/en/ichra/employees/handbooks-forms.html. 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 with us to assist us in determining our rights and obligations under this *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; and
3. 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 this *contract*.

Time for Payment of Claims

Benefits will be paid immediately upon receipt of *proof of loss*. Should we determine that additional supporting documentation is required to establish responsibility of payment, we shall pay benefits upon receipt of such additional supporting documentation.

Payment of Claims

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

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

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

If a proper claim is submitted by a public *hospital* or clinic, benefits payable will be paid to such *hospital* or clinic with or without an assignment from you or your dependent. Payment of benefits to the public *hospital* or clinic pursuant to this paragraph shall discharge us from all liability to you or your dependent to the extent of benefits paid.

Claims Incurred for Emergency Services While Traveling Outside the United States

Medical *emergency services* are covered for up to 90 consecutive days while traveling outside the United States. If travel extends beyond 90 consecutive days, no benefit coverage is provided for *emergency services* for the entire period of travel, including the first 90 days.

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

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 your health insurance benefits are assigned by you in writing, and 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 this *contract* except for the right to receive benefits, if any, that we have determined to be due and payable.

Custodial Parent

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

Upon request by the custodial parent, we will:

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

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

Physical Examination

At our own expense we have the right and opportunity to examine a *member* when and as often as we may reasonably require during the pendency of a claim, and to make an autopsy in case of death where is not forbidden by *applicable law*.

Legal Actions

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

No 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.

Right of Claims Recovery

Except in cases of fraud or misrepresentation by the health care provider, if the amount of the payments made by this plan is more than we should have paid we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the *member*. We have the right to recover from any claim 12 months after payment is made based on *applicable law*.

COMPLAINT AND APPEAL PROCESS

The following processes are available to address your problems and concerns. In addition, communicating a *complaint* or *appeal* will not affect your health care benefits or services and we will not treat you differently.

Call Member Services

We want to know your concerns so we can improve our services. Please contact our Member Services team if you have questions or concerns. We will attempt to resolve your concern on your initial contact.

Complaint Process

You or your *authorized representative* may file a *complaint* by calling our Member Services Team or in writing by mailing or faxing your *grievance* to:

Ambetter Health
Attn: Appeals and Grievance Department
PO Box 10341
Van Nuys, CA 91410
Fax 1-833-886-7956

If filing a written *complaint*, please include:

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

Resolution Timeframe

Complaints will be promptly investigated. We will acknowledge your *complaint* by sending you a letter within ten business days of receipt of your *complaint*.

We will promptly investigate your *complaint* and provide a response within 20 business days after receipt of the *complaint* or within 30 calendar days, whichever is less. If the investigation cannot be completed within 20 business days after receipt of the *complaint*, the *member* shall be notified in writing on or before the 20th business day and the investigation shall be completed within 30 business days thereafter. The notice shall set forth with specificity the reasons for which additional time is needed for the investigation.

Urgent *complaints* are resolved as expeditiously as possible, no later than 72 hours after Ambetter Health receives the *complaint*.

Within five business days after the investigation is completed, someone not involved in the circumstances giving rise to the *complaint* or its investigation will decide upon the appropriate resolution of the *complaint* and notify you in writing of the health carrier's decision regarding the *complaint* and of the right to file an *appeal*. Within 15 business days after the investigation is completed, we will notify the person who submitted the *complaint* of the resolution of said *complaint*.

Appeal Process

You have up to 180 calendar days to file an *appeal* from the date you receive the decision that you are requesting be overturned. You or your *authorized representative* may file an *appeal* in writing by mail or by fax at 1-855-805-9812. Please send your written *appeal* to:

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

When filing your *appeal*, we ask that you provide a reason along with any information to support why your *appeal* should be approved. If you would like to file your *appeal* by telephone, you may call Member Services.

Please include in your written *appeal* or be prepared to tell us the following:

1. Name, address and telephone number of the *member*;
2. The *member's* health plan identification number;
3. Name of health care provider, address and telephone number;
4. Date the health care benefit was provided (if a post-claim denial *appeal*);
5. Name, address and telephone number of an *authorized representative* (if *appeal* is filed by a person other than the *member*); and
6. A copy of the notice of *adverse benefit determination*, if applicable.

Who Can File an Appeal

You have the right to have someone else help you with filing an *appeal*. This can be a relative, friend, lawyer, your doctor or health care provider, or other person. To have someone else file an *appeal* for you, we must have your written permission for that person to file an *appeal* on your behalf. You will need to obtain and fill out an *Authorized Representative* Designation form and return it to us so we will know who you have granted permission to represent you. The *Authorized Representative* Designation form can be obtained by calling Member Services or by visiting our website at Ambetterhealth.com.

Rescission of Coverage

If we rescind (withdraw) your coverage, you may file an *appeal* according to the following procedures. *Rescission* may only occur in cases of fraud or intentional misrepresentation of material fact, as permitted by *applicable law*. We cannot terminate your benefits until all of the *appeals* have been exhausted. Since a *rescission* means that no coverage ever existed, if our decision to rescind is upheld, you will be responsible for payment of all claims for your *health care services*.

Resolution Timeframe

If you file an *appeal*, an acknowledgement letter will be sent within ten business days from when the *appeal* was received by Ambetter.

The *appeal* investigation will be completed, and response provided within 20 business days after receipt of your *appeal* or within 30 calendar days, whichever is less. If additional time is needed and

agreed upon by you, you will be notified in writing before the 20th business day with specific reasons why the additional time is needed, and the additional time will be no greater than 14 calendar days. Within five business days after the investigation resolution someone not involved in the circumstances giving rise to the *appeal* or its investigation will decide upon the appropriate resolution of the *appeal* and notify you in writing of our decision regarding the *appeal*.

Expedited Review

You or your *authorized representative* or provider acting on your behalf may request an expedited review when a non-expedited review would reasonably appear to seriously jeopardize the life or health of the *member* or jeopardize the *member's* ability to regain maximum function. A request for an expedited review may be submitted orally or in writing.

Upon receipt of request for an expedited review of a determination, we will notify you within 72 hours and written confirmation provided within three business days of the determination notice.

Access to Documents Relevant to the Appeal

You are entitled to receive, upon request and at no additional cost, reasonable access to and copies of all documents relevant to the *appeal* including any new or additional evidence. Relevant documents include documents and records relied upon in making the *appeal* decision and documents and records submitted in the course of making the *appeal* decision.

Request for External Review by an Independent Review Organization

If the Missouri Department of Commerce and Insurance (DCI) is unable to resolve your *appeal* regarding a determination of whether surprise billing protections apply and the *member cost sharing* that applies for services subject to surprise billing protections or the medical necessity, appropriateness, health care setting, level of care, or effectiveness of *health care service*, the Missouri DCI may select an *Independent Review Organization (IRO)* to review your *appeal*.

For the purposes of the *appeals* process, an *Independent Review Organization (IRO)* means an entity that is accredited by a nationally recognized private accrediting organization to conduct independent external reviews of *adverse benefit determinations* and by the Missouri DCI in accordance with Missouri law. The IRO is composed of persons who are not employed by Ambetter or any of its affiliates.

If the director of the DCI determines an *appeal* is unresolved after completion of DCI's consumer *complaint* process, DCI shall refer the unresolved *appeal* to an IRO. An unresolved *appeal* shall include a difference of opinion between a treating *physician* and the health carrier concerning the medical necessity, appropriateness, health care setting, level of care or effectiveness of a *health care service*.

The DCI will provide the IRO and upon request the *member*, *member's authorized representative* or health carrier copies of all medical records and any other relevant documents which the DCI has received from any party. The *member*, *member's authorized representative* and health carrier may review all the information submitted to the IRO for consideration.

The *member*, *member's authorized representative* or health carrier may also submit additional information to the DCI which the DCI shall forward to the IRO. All additional information must be received by the DCI. If a *member*, *member's authorized representative* or health carrier has information which contradicts information already provided the IRO, they should provide it as

additional information. All additional information should be received by the DCI within 15 business days from the date the DCI mailed that party copies of the information provided to the IRO. An envelope's postmark shall determine the date of mailing. Information may be submitted to the DCI by means other than mail if it is in writing, typeset or easily transferred into typeset by the DCI's technology and a date of transmission is easily determined by the DCI. At the DCI's discretion, additional information which is received past the 15 working-day deadline may be submitted to the IRO.

The IRO shall request from the DCI any additional information it wants. The DCI shall gather the requested information from a *member*, *member's authorized representative* or health carrier or other appropriate entity and provide it to the IRO. If the DCI is unable to obtain the requested information, the IRO shall base its opinion on the information already provided.

Within 20 calendar days of receiving all material, the IRO shall submit to the DCI its opinion of the issues reviewed. Under exceptional circumstances, if the IRO requires additional time to complete its review, it should request in writing from the director an extension in the time to process the review, not to exceed five calendar days. Such a request should include the reasons for the request and a specific time at which the review is expected to be complete.

After the director receives the IRO's opinion, the director shall issue a decision which shall be binding upon the *member* and the health carrier. The director's decision shall be in writing and must be provided to the *member* and health carrier within 25 calendar days of receiving the IRO's opinion. In no event shall the time between the date the IRO receives the request for external review and the date the *member* and the health carrier are notified of the director's decision be longer than 45 days.

A *member* or *member's authorized representative* or health carrier may request an expedited external review if the adverse determination:

1. Concerns an admission, availability of care, continued stay, or *health care service* for which the *member* received *emergency services*, but has not been discharged from a *facility*; or
2. Involves a medical condition for which the delay occasioned by the standard external review time frame would jeopardize the life or health of the *member* or jeopardize the *member's* prognosis or ability to regain maximum function.

As expeditiously as possible after receipt of the request for expedited external review by the IRO, the IRO must issue its opinion as to whether the adverse determination should be upheld or reversed and submit its opinion to the director. As expeditiously as possible, but within no more than 72 hours after the receipt of the request for expedited external review by the IRO, the director shall issue notice to the *member* and the health carrier of the director's determination and may issue a decision to uphold or reverse the adverse determination. If the notice is not in writing, the director must provide the written decision within 48 hours after the date of the notice of the determination.

If a request for external review of an adverse determination involves a denial of coverage based on a determination that the *health care service* or treatment recommended or requested is *experimental or investigational*, the following additional requirements must be met:

1. The IRO shall make a preliminary determination as to whether the recommended or requested *health care service* or treatment that is the subject of the adverse determination is a *covered service* under the person's health benefit plan except for the health carrier's determination that the service or treatment is *experimental or investigational* for a particular medical condition; and is not explicitly listed as an excluded benefit under the *member's* health benefit plan with the health carrier;

2. The request for external review of an adverse determination involving a denial of coverage based on a health carrier's determination that the *health care service* or treatment recommended or requested is *experimental or investigational* must include a certification from the *member's physician* that:
 - a. Standard *health care services* or treatments have not been effective in improving the condition of the *member*;
 - b. Standard *health care services* or treatments are not medically appropriate for the *member*;
 - c. There is no available standard *health care service* or treatment covered by the health carrier that is more beneficial than the recommended or requested *health care service* or treatment; and
 - d. The request for external review of an adverse determination involving the denial of coverage based on a determination that the requested treatment is *experimental or investigational* shall also include documentation:
 - i. That the *member's* treating *physician* has recommended a *health care service* or treatment that the *physician* certifies, in writing, is likely to be more beneficial to the *member*, in the *physician's* opinion, than any available standard *health care services* or treatments; or
 - ii. That the *member's* treating *physician*, who is a licensed, board-certified, or board-eligible *physician* qualified to practice in the area of medicine appropriate to treat the *member's* condition, has certified in writing that scientifically-valid studies using accepted protocols demonstrate that the *health care service* or treatment requested by the *member* that is the subject of the adverse determination is likely to be more beneficial to the *member* than any available standard *health care services* or treatments.
3. When conducting such an external review, the IRO must select one or more clinical peers, who must be *physicians* or other *medical practitioners* who meet minimum qualifications and through clinical experience in the past three years are experts in the treatment of the *member's* condition and knowledgeable about the recommended or requested *health care service* or treatment. Each clinical peer shall provide a written opinion to the assigned IRO on whether the recommended or requested *health care service* or treatment should be covered; and
4. Each such clinical peer's opinion submitted to the IRO shall include the following information:
 - a. A description of the *member's* medical condition;
 - b. A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested *health care service* or treatment is more likely than not to be beneficial to the *member* than any available standard *health care services* or treatments and the adverse risks of the recommended or requested *health care service* or treatment would not be substantially increased over those of available standard *health care services* or treatments;
 - c. A description and analysis of any medical or scientific evidence considered in reaching the opinion;

- d. Information on whether the reviewer's rationale for the opinion is based upon whether the recommended or requested *health care service* or treatment has been approved by the federal Food and Drug Administration for the condition, or whether medical or scientific evidence or evidence based standards demonstrate that the expected benefits of the recommended or requested *health care service* or treatment is more likely than not to be beneficial to the *member* than any available standard *health care service* or treatment and the adverse risks of the recommended or requested *health care service* or treatment would not substantially be increased over those of available standard *health care services* or treatments; and
- e. A description and analysis of any evidence-based standard.

If we decide to reverse our adverse determination before or during the external review, we will notify you and the Missouri DCI, within one business day of the decision.

If the IRO reverses our decision, we will immediately provide coverage for the *health care service* or services in question.

If the IRO and Missouri DCI upholds our decision, you may have a right to file a lawsuit in any court having jurisdiction.

Complaints received from the Missouri Department of Commerce and Insurance

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

You have the right to file a *complaint* or *grievance* with the Missouri DCI at any time. The Missouri DCI may be contacted at the following address and telephone number:

Missouri Department of Commerce and Insurance
Attn: Division of Consumer Affairs
P.O. Box 690
Jefferson City, MO 65102
Phone: 1-800-726-7390

GENERAL PROVISIONS

Entire Contract

This *contract*, the *Schedule of Benefits*, and the enrollment application, including any riders or amendments attached, is the entire *contract* between you and us. No change in this *contract* will be valid unless it is approved by one of our officers and noted on or attached to this *contract*. 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.

Personal Health Information (PHI)

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

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

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

Language Assistance

If you don't speak or understand the language in your area, you have the right to an interpreter. For language assistance, please visit: Ambetterhealth.com/language-assistance.html.

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 this *contract* that will not be considered a waiver of any rights under this *contract*. A past failure to strictly enforce this *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, and any amendments, has been furnished to the *member(s)*, or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to our determination to issue coverage to any *member*. A *member's* coverage will be voided/rescinded, and claims denied if that person performs an act or practice that constitutes fraud. "Rescind" has a retroactive effect and means the coverage was never in effect.

Time Limit on Certain Defenses

After two years from the date of issue of this *contract* no misstatements, except fraudulent misstatements, made by you in the enrollment application for your contact may be used to void your *contract* or to deny a claim for *loss* incurred commencing after the expiration of such two-year period. In accordance with the foregoing, we have the right to terminate this *contract* if you commit fraud or make a material misrepresentation during the enrollment application process, or we determined termination is appropriate to ensure compliance with *applicable laws*.

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