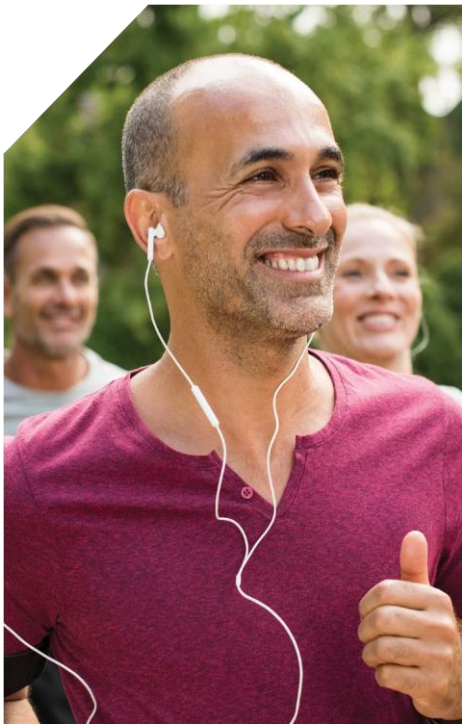




2027 EVIDENCE OF COVERAGE

Ambetter + Adult Vision + Adult Dental





AmbetterHealth.com/en/PA

Ambetter Health

Underwritten by Ambetter Health of Pennsylvania, Inc.

Home Office: 1700 Bent Creek Boulevard, Suite 200, Mechanicsburg, PA 17050

Major Medical Expense Insurance Policy

Ambetter + Adult Vision + Adult Dental

In this *policy*, the terms "you" or "your" will refer to the *member* or any dependents enrolled in this *policy*. The terms "we", "our" or "us" will refer to Ambetter Health.

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

Annually, we must file this product, the *cost share* and the rates associated with it for approval. Guaranteed renewable means that your *policy* will be renewed into the subsequent year's approved product on the anniversary date unless terminated earlier in accordance with *policy* terms. You may keep this *policy* (or the new *policy* 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 *policy* each year, however, we may decide not to renew the *policy* as of the renewal date if: (1) we decide not to renew all policies issued on this form, with a new *policy* 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 *policy* benefits.

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

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

This *policy* 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 Utilization Management section.

RIGHT TO RETURN POLICY

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



Marc S. Giordano
Plan President & CEO

TABLE OF CONTENTS

INTRODUCTION **8**
How to Contact Us 8
Interpreter Services 8
IMPORTANT INFORMATION **9**
Provider Directory 9
Member Identification Card 9
Website 9
Quality Improvement 10
Protection from Balance Billing 10
MEMBER RIGHTS AND RESPONSIBILITIES **12**
DEFINITIONS **16**
DEPENDENT MEMBER COVERAGE **35**
Dependent Member Eligibility 35
Effective Date for Initial Dependent Members 35
Coverage for a Newborn Child 35
Coverage for an Adopted Child 35
Adding Other Dependent Members 36
Military Membership or Active-Duty Dependents 36
ELIGIBILITY AND ENROLLMENT **37**
For All Members 37
For Dependent Members 37
Open Enrollment 37
Special Enrollment Periods 38
Prior Coverage 39
PREMIUMS **40**
Premium Payment 40
Grace Period 40
Third-Party Payment of Premiums or Cost Sharing 40
Misstatement of Age 41
Change or Misstatement of Residence 41
Misstatement of Tobacco or Nicotine Use 41
Health Savings Account (HSA) 41
UTILIZATION MANAGEMENT **43**

Authorization Requirements 43
How to Obtain Prior Authorization 44
Failure to Obtain Prior Authorization 44
Authorization Does Not Guarantee Benefits 44
Requests for Predeterminations 44
Services from Non-Network Providers 45
COST SHARING FEATURES 46
Deductible 46
Copayments 46
Coinsurance 46
Maximum Out-of-Pocket 47
Non-Network Liability and Balance Billing 47
ACCESS TO CARE 48
Primary Care Physician (PCP) 48
Contacting Your Primary Care Physician (PCP) 49
Changing Your Primary Care Physician (PCP) 49
Non-Emergency Services 49
Hospital Based Providers 49
Emergency Services Outside of Service Area 50
Continuity of Care 50
New Technology 50
Preferred Partnership 50
Network Availability 51
Coverage Under Other Policy Provisions 51
MAJOR MEDICAL EXPENSE BENEFITS 52
Acquired Brain Injury Services 52
Ambulance Services 53
Autism Spectrum Disorder Benefits 55
BRCA Screening Coverage 55
Chiropractic Services 55
Care Management Programs 55
Clinical Trial Coverage 56
Dental Benefits – Adults 19 years of age or older 57
Diabetic Care 59
Dialysis Services 59

Disposable Medical Supplies 60
Durable Medical Equipment, Medical and Surgical Supplies, Orthotic Devices and Prosthetics 60
Emergency Services 64
Family Planning and Contraception 65
Fertility Preservation 66
Habilitation, Rehabilitation, and Extended Care Facility Expense Benefits 66
Home Health Care Service Expense Benefits 66
Hospice Care Service Expense Benefits 67
Hospital Benefits 68
Infertility 68
Long Term Acute Care 69
Lymphedema 70
Mammography 70
Maternity Care 70
Medical and Surgical Expense Benefits 72
Medical Foods and Nutritional Services 76
Medical Dental Services 77
Medical Vision Services 78
Mental Health and Substance Use Disorder Benefits 78
Pediatric Vision Benefits – Children under the age of 19 80
Prescription Drug Expense Benefits 81
Preventive Care Expense Benefits 87
Prostate Specific Antigen Testing 89
Radiology, Imaging and Other Diagnostic Testing 90
Second Medical Opinion 90
Sleep Studies 90
Transplant Expense Benefits 90
Urgent Care 94
Vision Benefits – Adults 19 years of age or older 94
WELLNESS PROGRAMS AND OTHER OFFERINGS 96
GENERAL NON-COVERED SERVICES AND EXCLUSIONS 97
TERMINATION 102
Termination of Policy 102
Refund upon Cancellation 102

Reinstatement 102
Discontinuance 103
SUBROGATION AND RIGHT OF REIMBURSEMENT 104
COORDINATION OF BENEFITS 106
Order of Benefit Determination Rules 107
Effects of Coordination 109
Right to Receive and Release Needed Information 109
Facility of Payment 109
Right of Recovery 109
CLAIMS 110
Notice of Claim 110
Claim Forms 110
Proof of Loss 110
How to Submit a Claim 110
Cooperation Provision 111
Time for Payment of Claims 111
Payment of Claims 111
Time Limit on Certain Defenses 112
Claims Incurred for Emergency Services While Traveling Outside the United States 112
Assignment 112
Medicaid Reimbursement 113
Custodial Parent 113
Physical Examination 113
Legal Actions 113
Non-Assignment 114
No Third-Party Beneficiaries 114
GRIEVANCE AND APPEAL PROCEDURES 115
Internal Procedures 115
Grievances 115
Appeals 115
Review Committee 118
Expedited Appeal 119
Complaints Received from the State Insurance Department 120
External Review 120
GENERAL PROVISIONS 124

Entire Policy 124
Non-Waiver 124
Rescissions 124
Repayment for Fraud, Misrepresentation or False Information 124
Conformity with Applicable Laws 125
Personal Health Information (PHI) 125
Language Assistance 125

INTRODUCTION

Welcome to Ambetter Health! We have prepared this *policy* to help explain your coverage. Please refer to this *policy* 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 *policy*, the *Schedule of Benefits*, the enrollment application as submitted to the Pennsylvania Insurance Exchange (Exchange), and any amendments and riders attached shall constitute the entire *policy* under which *covered services* and supplies are provided or paid for by us.

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

How to Contact Us

Contact us at:

Ambetter Health
1700 Bent Creek Boulevard, Suite 200
Mechanicsburg, PA 17050

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

Member Services:.....	**1-833-510-4727**
TTY line:	Relay **711**
Fax:.....	**1-833-818-9887**
Emergency:	**911**
Suicide and Crisis Lifeline:	988 (call or text)
24/7 Nurse Advice Line:....	**1-833-510-4727**

Interpreter Services

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

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

To arrange for interpretation services, please call Member Services.

IMPORTANT INFORMATION

Provider Directory

A listing of *network* providers is available online at AmbetterHealth.com/en/PA. 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, languages spoken, and whether or not they are currently accepting new patients. Your search will produce a list of providers based on your search criteria and will give you other information such as name, address, phone number, office hours, specialty, and board certifications.

At any time, you can request a copy of the provider directory at no charge by calling Member Services. In order to obtain benefits, you must designate a *network primary care physician* ("*PCP*") for each *member*. We can help you pick a *PCP*. We can make your choice of *PCP* effective on the next business day.

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

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

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

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 the *policy*. The *member* identification card will show your name, *member* identification number, and *copayment amounts* required at the time of service. Any applicable *deductibles*, and any applicable *maximum out-of-pocket amount* limitations will also be accessible through the *member* identification card. If you do not get your *member* identification card within a few weeks after you enroll, please call Member Services. We will send you another card. A temporary *member* identification card can be downloaded from our secure online *member* account 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/en/PA. It also gives you information on your benefits and services such as:

1. Finding a *network* provider, including *hospitals* and pharmacies.
2. Our programs and services, including programs to help you get and stay healthy.
3. A secure portal for you to check the status of your claims, make payments, and obtain a copy of your *member* identification card.
4. Member Rights and Responsibilities.
5. Notice of Privacy Practices.
6. Current events and news.
7. Our formulary or *prescription drug* list.
8. *Deductible* accumulators.
9. Selecting a *PCP*.

Quality Improvement

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

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

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

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

Protection from Balance Billing

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

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

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

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

You have the right to:

1. Participate with your *physician* and *medical practitioners* in decisions about your health care. This includes working on any treatment plans and making care decisions. You should know any possible risks, problems related to recovery, and the likelihood of success. You shall not have any treatment without consent freely given by you or your legally *authorized representative*. You will be informed of your care options.
2. Know who is approving and performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which you have coverage.
4. Be treated with respect and dignity.
5. Privacy of your personal health information, consistent with state and federal laws, and our policies.
6. Receive information or make recommendations, including changes, about our organization and services, our *network* of *physicians*, *medical practitioners*, *hospitals*, other facilities, and your rights and responsibilities.

7. Candidly discuss with your *physician* and *medical practitioners* appropriate and *medically necessary* care for your condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *PCP* about what might be wrong (to the level known), treatment and any known likely results. Your *PCP* can tell you about treatments that may or may not be covered by this *policy*, regardless of the cost. You have a right to know about any costs you will need to pay. This should be told to you in words you can understand. When it is not appropriate to give you information for medical reasons, the information can be given to a legally *authorized representative*. Your *physician* will ask for your approval for treatment unless there is an emergency, and your life and health are in serious danger.
8. Voice *complaints* or *grievances* about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
9. See your medical records.
10. Be kept informed of covered and non-covered services, program changes, how to access services, *PCP* assignment, providers, advance directive information, referrals and *authorizations*, benefit denials, *member* rights and responsibilities, and our other rules and guidelines. We will notify you at least 60 calendar days before the *effective date* of the modifications. Such notices shall include:
    a. Any changes in clinical review criteria; or
    b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
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 expected health 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 provider(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; or
    c. “Do Not Resuscitate” orders.

You have the responsibility to:

1. Read this entire *policy*.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about your health that we or your *medical practitioners* need in order to provide care. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your *physician* until you understand the care you are receiving.
4. Review and understand the information you receive about us. You need to know the proper use of *covered services*.
5. Show your *member* identification card and keep scheduled appointments with your *physician* and call the *physician’s* office during office hours whenever possible if you have a delay or cancellation.
6. Know the name of your assigned *PCP*. You should establish a relationship with your *physician*. You may change your *PCP* verbally or in writing by contacting Member Services.
7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
8. Understand your health problems and participate, along with your health care professionals and *physicians* 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 health care professionals and *physician*.
10. Tell your health care professional and *physician* if you do not understand your treatment plan or what is expected of you. You should work with your *PCP* to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.

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. When you enroll in this coverage, give all information about any other medical coverage you have. If, at any time, you get other medical coverage besides this coverage, you must tell the entity with which you enrolled.
14. Pay your monthly premium, *deductible amount*, *copayment amounts*, and *coinsurance amounts* on time.
15. Notify us or the entity in which you enrolled with of any enrollment related changes that would affect your *policy* within 60 calendar days of the event. Enrollment related changes include the following: birth of a child, adoption, marriage, divorce, change of address, adding/removing a dependent, *spouse*/domestic partner becomes eligible under a different insurer, or incarceration where *member cost share* would need to transfer from one *policy* to another *policy*.

DEFINITIONS

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

Wherever used in this *policy*:

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

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

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

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

1. A denial of a request for service.
2. A denial, reduction or failure to provide or make payment in whole or in part for a *covered service*.
3. A determination that an admission, continued stay, or other health care service does not meet our requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness.
4. A determination that a service is *experimental*, *investigational*, *cosmetic treatment*, not *medically necessary* or inappropriate.
5. 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*.

Allowed amount (also see *eligible expense*) means the maximum amount we will pay a provider for a *covered service*. When a *covered service* is received from a *network* provider, the *allowed amount* is the amount the provider agreed to accept from us as payment for that particular service. In all cases, the *allowed amount* will be subject to *cost sharing* (e.g., *deductible*, *coinsurance* and *copayment*) per the *member's* benefits. This amount excludes 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 *policy*. See *Balance billing*, *Balance billing protections*, and *non-network provider* definitions for additional information. If you are *balance billed* in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.

Ambetter-designated telehealth provider means the vendor selected by Ambetter to contract with providers to render *telehealth services*, including *Virtual 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 does not include facilities such as acute-care clinics, *urgent care centers*, ambulatory-care clinics, free-standing emergency facilities, and *physician* offices.

Appeal means a request to reconsider a decision about the *member's* benefits where either a service or claim has been denied. An *appeal* is submitted to request that Ambetter reconsider a decision solely concerning the *medical necessity* and appropriateness of health care services, which are regarding an adverse determination decision that does any of the following:

1. Disapproves full or partial payment for a requested health service.
2. Approves the provision of a requested health care service for a lesser scope or duration than requested.
3. Disapproves payment of the provision of a requested health care service but approves payment for the provision of an alternative health care service.

An *appeal* may also refer to a request for a second review of our initial or first level *grievance* decision.

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

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

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

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

1. A person to whom a *member* has given express, written consent to represent that individual in an internal *appeal* 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 health care professional, but only when the *member* is unable to provide consent.

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

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

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

1. *Emergency services* provided to a *member*, as well as services provided after the *member* is *stabilized* unless the *member* gave *notice and consent* to be *balance billed* for the *post-stabilization services*;
2. Non-emergency health care services provided to a *member* at a *network hospital* or at a *network ambulatory surgical center* unless if *member* gave *notice and consent* pursuant to the federal No Surprises Act to be *balance billed* by the *non-network provider*; or
3. Air ambulance services provided to a *member* by a *non-network provider*. You will only be responsible for paying your *member cost share* for these services, which is calculated as if you had received the services from a *network* provider and is based on the recognized amount as defined in *applicable law*. If you are *balance billed* for any of the above services, contact Member Services immediately at the number listed on the back of your *member* identification card.

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

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

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

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

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

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

Coinsurance amount or ***coinsurance*** 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, or the coverage (including contract exclusions and non-covered services), operations or management policies of Ambetter, that has not been resolved and has been filed with Ambetter or the Department of Insurance. The term *complaint* does not include *grievance*.

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* and not, from a medical viewpoint, associated with a normal *pregnancy*. This includes ectopic *pregnancy*, spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity.

It does not include false labor, preeclampsia, edema, prolonged labor, *physician* prescribed rest during the period of *pregnancy*, morning sickness, and conditions of comparable severity associated with management of a difficult *pregnancy*, and not constituting a medically classifiable distinct *complications of pregnancy*.

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

1. Undergoing a treatment for a *serious and complex condition* from that provider or facility;
2. Undergoing a course of institutional or *inpatient* care from that provider or facility;

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

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

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

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

Cost sharing reductions mean reductions that lower the amount you have to pay in *deductibles*, *copayments* and *coinsurance*. To qualify for *cost sharing reductions*, an eligible individual must enroll in a silver level plan through the Exchange. *Members* of a federally recognized American Indian tribe and/or an Alaskan Native may qualify for additional *cost sharing reductions*.

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

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

Custodial care means 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.

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

Deductible amount or ***deductible*** means the amount that you must pay in a *calendar year* for *covered 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*.

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

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

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

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

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

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

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

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

1. For *network* providers: When a *covered service* is received from a *network* provider, the *eligible expense* is the contracted fee with that provider.
2. For *non-network providers*, unless otherwise required by federal or Pennsylvania law, the *eligible expense* is as follows:

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

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

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

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

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

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

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

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

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

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("FDA") regulation, regardless of whether the trial is subject to FDA oversight.
2. An *unproven service*.
3. Subject to FDA approval; and:
    a. It does not have FDA approval;
    b. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation;
    c. It has FDA approval but is being used 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 (3) and (4) above do not apply to phase III or IV FDA clinical trials. Benefits are available for routine care costs that are incurred in the course of a clinical trial if the services provided are otherwise *covered services* under this *policy*.

Extended care facility (ECF) means a facility that is primarily engaged in providing comprehensive post-acute *hospital* and *inpatient* rehabilitative care and is licensed by the designated government agency to provide such services. The definition of an *ECF* does not include institutions that provide only minimal, custodial, assisted living, independent living

communities, extended nursing homes, residential care homes, ambulatory or part-time care services, or institutions that primarily provide for the care and treatment of *behavioral health* or pulmonary tuberculosis.

External review means a review by an *independent review organization* of a plan's decision to deny coverage for or payment of a service.

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

If no credible scientific evidence is available, then standards based on *physician* specialty society recommendations or professional standards of care may be considered. We reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered service* under the *policy*. The decision to apply *physician* specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by us. 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 any expression of dissatisfaction communicated to us by the *member*, or a *member's authorized representative*, about our services, coverage, providers, or related to our operations and management policies that have not been resolved by Ambetter. These disputes can be filed directly to us or the Pennsylvania Insurance Department. The term *grievance* does not include an *appeal*. (Contract exclusions and non-covered services concerns can be resolved by Member Services. If dissatisfied with information provided, a formal *grievance* may be filed.).

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

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

Home health care means care or treatment of an *illness* or *injury* at the *member's* home that is 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.
4. Provides each patient with a planned program of observation and treatment by a *physician*, in accordance with existing standards of medical practice for the *injury* or *illness* requiring the *home health care*.

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

Hospice means services designed for and provided to *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*.

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

Hospital means an institution that:

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

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*. Furthermore, if an *illness* is due to causes that are the same as, or related to, the causes of a prior *illness*, the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

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

Independent Review Organization (IRO) means an organization that determines whether a health insurance company was correct to refuse to pay for health care services for a *member* based on the coverage provided by the *policy* and the medical judgment of health care professionals. *IROs* do not work for the insurance companies and can fairly decide whether the insurance company or the *member* is correct.

Injury or ***injuries*** means accidental bodily damage sustained by a *member*.

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

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

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

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

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

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

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

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

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

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

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

Mental health disorder means a condition - 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, behavioral and neurodevelopmental disorders chapter of the most current edition of the *International Classification of Diseases* or that is listed in the most current 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, Pennsylvania Insurance Exchange ("Exchange") plans, most individual plans sold outside of the Exchange, Medicare, Medicaid, Children Health Insurance Program (CHIP), TRICARE, and COBRA plans sold through the Small Business Health Insurance Program (SHOP) Marketplace.

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

They are not 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.

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

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

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

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

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

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

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

1. The *non-network provider* provides the *member* a written notice in the format required by *applicable law* that states the provider is a *non-network provider*, includes a good-faith estimate of the *non-network provider*'s charges for the services, identifies any *prior authorization* or other limitations that may be required in advance of receiving the services, and clearly states that consent is optional, and the *member* may seek care from a *network* provider.
2. The *non-network provider* provides the notice described above to the *member* at least 72 hours before the services are furnished, except that for services scheduled within 72 hours, the notice must be provided at least 3 hours before the services are furnished.
3. The *member* provides written consent to be treated by the *non-network provider* that includes the following:
    a. The *member's* acknowledgement that they have been provided written notice as described above and informed that payment of the *non-network provider*'s *billed amount* may not accrue toward the *member's deductible* or *maximum out-of-pocket amount*;
    b. The *member's* statement that by signing the consent, they agree to be treated by the *non-network provider* and understand they may be *balance billed* and subject to cost-sharing that applies to *non-network 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 for therapeutic support, protection, restoration or function of an impaired body part for treatment of an *illness* or *injury*.

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

Other practitioner means, as used in your *Schedule of Benefits* and related to *mental health disorder*/*substance use disorder* services, refers to a *mental health disorder* 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.

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

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

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

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

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 claimant obtaining the medical care.

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

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

Prescription drug deductible amount means the amount of *covered services*, shown in the *Schedule of Benefits*, if applicable, that must actually be paid during any *calendar year* before any *prescription drug* benefits are payable. The family *prescription drug deductible amount* is two times the individual *prescription drug deductible amount*. For family coverage, once a *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 expenses*.

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

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

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

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

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

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

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

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

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

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

Rehabilitation facility means an institution or a separate identifiable *hospital* unit, section, or ward that is licensed by the state as a *rehabilitation facility*, and operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as inpatients.

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

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

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

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

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

Residential treatment facility (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 *policy* for an *RTF* admission is based on medical necessity.

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

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

Self-injectable drugs mean *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 Pennsylvania to sell and market our health plans. This is where the

majority of *network* providers are located where you will receive all of your health care services and supplies. You can receive precise *service area* boundaries from our website or *Member* Services.

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

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

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

Specialty drug means a *prescription drug* used to treat rare, complex, chronic or life-threatening conditions that may require special handling, storage, administration, monitoring or clinical management.

Spouse means the person to whom you are lawfully married.

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

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

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 recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Surgery or ***surgical procedure*** means 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 who has a fertilized egg placed in her body, but the egg is not her own.

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

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

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

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

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

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

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

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

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

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

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

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

DEPENDENT MEMBER COVERAGE

Dependent Member Eligibility

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

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

Effective Date for Initial Dependent Members

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

Coverage for a Newborn Child

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

In order for the newborn child to be covered beyond the 31st calendar day after birth, we must receive notification of the birth. In addition, additional premium will be required to continue coverage beyond the 31st calendar day after the date of birth. The required premium will be calculated from the 31st calendar day after the child's date of birth. If notice is given by the Exchange within 60 calendar days of the birth of the child, we may not deny coverage of the child due to failure to notify us of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st calendar day after birth unless we have received notice by the Exchange of the child's birth.

Coverage for an Adopted Child

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

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

Additional premium will be required to continue coverage beyond the 31st calendar day following placement of the child and we have received notification from the Exchange. 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 from the Exchange within 60 calendar days of the birth or placement and (b) any additional premium required for the addition of the child within 90 calendar days of the date of placement.

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

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

Adding Other Dependent Members

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

Military Membership or Active-Duty Dependents

Pursuant to 51 Pa. C.S. §7309(d), prior to attaining the limiting age for an *eligible child* and while a full-time student, if the *eligible child* is:

1. A member of the Pennsylvania national guard or any reserve component of the U.S. armed forces and was called or ordered to active duty, other than active duty for training for a period of 30 or more consecutive days; or,
2. A member of the Pennsylvania national guard who is ordered to active state duty, including duty under Pa. C.S. Ch. 76 (relates to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

Then the eligibility for the *eligible child* will be extended for a period equal to the duration of the *eligible child's* service on duty or active state duty or until the individual is no longer a full-time student regardless of the age of the *eligible child* when the educational program at the accredited educational institution was interrupted due to military duty.

As proof of eligibility, the *member* must submit a form to Ambetter Health approved by the Department of Military & Veterans Affairs (DMVA):

1. Notifying us that the *eligible child* has been placed on active duty;
2. Notifying us that the *eligible child* is no longer on active duty; and
3. Showing that the *eligible child* has re-enrolled as a full-time student in an accredited educational institution for the first term or semester starting 60 or more calendar days after their release from active duty.

ELIGIBILITY AND ENROLLMENT

For All Members

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

1. The *subscriber* resides outside the *service area* or moves permanently outside the *service area* of this *policy*;
2. The date of termination that the Health Insurance Marketplace provides to us upon your request of cancellation to the Health Insurance Marketplace, or if you enrolled directly with us, the last day of the month we receive a request from you to terminate this *policy*, or any later date stated in your request will be effective the last day of the requested month but no further than 60 calendar days in advance;
3. The date that a *member* is no longer within the grace period due to 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 a *member's* death.

If you have material modifications (examples include a change in life event such as marriage, death, or other change in family status) or questions related to your health insurance coverage, contact the Pennsylvania Insurance Exchange (Exchange) at Pennie.com or call 1-844-844-8040. If you enrolled through Ambetter, contact Member Services.

For Dependent Members

A *dependent member* will cease to be a *member* at the end of the premium period in which he or she ceases to be your *dependent member* due to divorce or if a child ceases to be an *eligible child*. For *eligible children*, the coverage will terminate the 31st day of December the year 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. Not capable of self-sustaining employment due to mental or physical disability that began before the age limit was reached; and
2. Mainly dependent on you for support.

Open Enrollment

Each year, there will be an open enrollment period where you may apply for or change coverage in a *qualified health plan* (*QHP*) through the Exchange 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 *policy* is contingent upon timely receipt of any necessary information and the initial premium.

Special Enrollment Periods

A *qualified individual* has 60 calendar days to report a qualifying event to the Exchange, and could be granted a 60-calendar day special enrollment period as a result of one of the following events:

1. A *qualified individual* or dependent experiences a *loss* of *minimum essential coverage*, non-calendar year group or individual health insurance coverage, pregnancy-related coverage, access to health care services through coverage provided to a pregnant *member's* unborn child, or medically needed coverage;
2. A *qualified individual* gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order; a. in the case of marriage, at least one *spouse* must demonstrate having *minimum essential coverage* as described in 26 CFR 1.5000A-1(b) for one or more days during the 60 calendar days preceding the date of marriage;
3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
4. An individual who is no longer incarcerated or whose incarceration is pending the disposition of charges;
5. A *qualified individual's* enrollment or non-enrollment in a *qualified health plan* is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
6. An *member* adequately demonstrates to the Exchange that the *qualified health plan* in which he or she is enrolled substantially violated a material provision of its *policy* in relation to the *member's* decision to purchase the *qualified health plan* based on plan benefits, *service area* or premium;
7. A *member* or *dependent member* enrolled in the same plan has a change in eligibility for *cost sharing reductions*;
8. A *qualified individual* or *member* gains access to new *qualified health plans* as a result of a permanent move;
9. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
10. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a *qualified health plan*, or change from one *qualified health plan* to another one time per month;

11. A *qualified individual* or *member* demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide;
12. A *qualified individual* or dependent is a victim of domestic abuse or spousal abandonment and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
13. A *qualified individual* or dependent is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 calendar days after the qualifying event;
14. At the option of the Exchange, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a *qualified health plan* through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315;
15. A *qualified individual* newly gains access to an employer sponsored individual coverage HRA or a Qualified Small Employer Health Reimbursement Arrangement (HRA);
16. A *qualified individual* or dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions or government subsidies completely cease.

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

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

Prior Coverage

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

If there is no prior coverage or no continuation of *inpatient* coverage after the *effective date*, your Ambetter 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-network *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 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

When a *member* is receiving a premium subsidy:

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

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

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

Premium payments are due in advance on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 60-calendar day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *policy* will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. We will notify the *member*, as well as providers, of the possibility of denied claims when the *member* is in the grace period.

Third-Party Payment of Premiums or Cost Sharing

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

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

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

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

Misstatement of Age

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

Change or Misstatement of Residence

If you change your *residence*, you must notify the Exchange 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 *policy*, we have the right to rerate the *policy* 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 Ambetter Health of Pennsylvania, Inc. Neither entity is an HSA trustee, HSA custodian or a designated administrator for HSAs. Ambetter Health, its designee and its affiliates, including Ambetter Health of Pennsylvania, Inc, 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

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

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

Authorization Requirements

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

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

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

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

Authorization requests or notification of admission (medical and *behavioral health*) must be received by phone/efax/provider portal as follows:

1. At least five calendar days prior to an elective admission as an *inpatient* in a *hospital*, extended care or *rehabilitation facility*, *hospice* facility, or *residential treatment facility*.
2. At least 30 calendar days prior to the initial evaluation for organ transplant services.
3. At least 30 calendar days prior to receiving clinical trial services.
4. 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.

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 business day or 24 hours of receipt of the request. For all other urgent concurrent reviews, within the lesser of one business day and 72 hours of receipt of the request.

2. For urgent pre-service reviews, the lesser of two business days or 72 hours from receipt of the request.
3. For non-urgent pre-service reviews, within two business days of receipt of the request.
4. For post-service or retrospective reviews, within 30 calendar days of receipt of the request.

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

If your *prior authorization* request has been denied, please refer to the Grievance and Complaint Procedures section of this *policy* for information on your right to *appeal* a denied *authorization*.

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.

How to Obtain Prior Authorization

To obtain *prior authorization* or to confirm that a *network* provider has obtained *prior authorization*, contact us by telephone at the telephone number listed on your *member* identification card before the service or supply is provided to the *member*.

Failure to Obtain Prior Authorization

Failure to comply with the *prior authorization* requirements will result in benefits being reduced.

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

Benefits will not be reduced for failure to comply with *prior authorization* requirements prior to receiving *emergency services*.

Authorization Does Not Guarantee Benefits

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

Requests for Predeterminations

You may request a predetermination of coverage. We will provide one if circumstances allow us to do so. However, we are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination we may make

will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause us to reverse the predetermination:

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

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

Services from Non-Network Providers

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

COST SHARING FEATURES

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

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

Deductible

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

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 is still responsible for their *deductible* 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

A *coinsurance* amount is your share of the cost of a service. *Members* may be required to pay a provider a *coinsurance* in addition to any applicable *deductible amount*(s) due for a *covered service* or supply. *Coinsurance amounts* do not apply toward the *deductible* but do apply toward your *maximum out-of-pocket amount*. When the annual *maximum out-of-pocket amount* has been met, additional *covered services* will be provided at 100 percent.

Maximum Out-of-Pocket

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

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

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

The amount provided or payable will be subject to:

1. Any specific benefit limits stated in the *policy*;
2. A determination of *eligible expenses*; and
3. Any reduction for expenses incurred at a *non-network provider*.

Please refer to the applicable *deductible amount*(s), *coinsurance amounts*, and *copayment amounts* in your *Schedule of Benefits*.

Non-Network Liability and Balance Billing

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

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

ACCESS TO CARE

Primary Care Physician (PCP)

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

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

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

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

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

Your *network PCP* will be responsible for coordinating all covered health services with other *network* providers. You may be required to obtain a referral from your *PCP* in order to receive care from a *specialist physician*. You do not need a referral from your *network PCP* for

behavioral health services, obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist.

Members with a life-threatening, degenerative or disabling disease or condition may, upon request, receive an evaluation by the health plan to allow for either a standing referral to a *specialist physician* with clinical expertise in treating the disease or condition, or the designation of a *specialist physician* to assume responsibility to provide and coordinate the *member's* primary and specialty care.

Contacting Your Primary Care Physician (PCP)

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

Should you need care outside of your *PCP's* office hours, you should call your *PCP's* office for information on receiving after hours care in your area. If you have an urgent medical problem or question or cannot reach your *PCP* during normal office hours, call our 24/7 nurse advice line at 1-833-510-4727 (Relay 711). A licensed nurse is always available and ready to answer your health questions. If you are experiencing an *emergency condition*, call 911 or for a *behavioral health emergency condition*, call 988 or go to the nearest emergency room.

Changing Your Primary Care Physician (PCP)

You may change your *network PCP* for any reason, with appropriate advance notice to us by submitting a written request, online at our website at AmbetterHealth.com/en/PA, 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.

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 providers outside of Pennsylvania 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.

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*.

Emergency Services Outside of Service Area

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

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

Continuity of Care

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

1. Notify each *member* who is a *continuing care patient* on a timely basis of the termination and their right to elect continued transitional care from the provider or facility;
2. Provide the individual with an opportunity to notify the health plan of the individual's need for transitional care; and
3. Permit the individual to elect to continue to have their benefits for the course of treatment relating to the individual's status as a *continuing care patient* during the period beginning on the date on which the above notice is provided and ending on the earlier of:
    a. 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 rates. 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*.

Network Availability

Your *network* is subject to change. The most current *network* may be found online at our website or by contacting us at the number shown on your identification card. A *network* may not be available in all areas. If you move to an area where we are not offering access to a *network*, please contact Member Services prior to moving, or as soon as possible. You may have the opportunity to disenroll from coverage under this *policy* and enroll in a different health plan with a *network* in that area.

Note: Services received from *non-network providers* are generally not *covered services* under this *policy*, 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 *policy* for *non-network providers*.

Coverage Under Other Policy Provisions

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

MAJOR 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 disorder* and *substance use disorder* services (including *behavioral health* treatment), *prescription drugs*, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services (including oral and vision care). Essential health benefits provided within this *policy* are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime or annual dollar maximum. 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 *policy*.

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

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

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.

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

To ensure that appropriate post-acute care treatment is provided, this plan includes coverage for 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, that with the provision of these services and support, the person can return to a community-based setting, rather than reside in a facility setting.

Ambulance Services

Ambulance Service Benefits (Ground/Water)

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

1. In cases where the *member* is experiencing an *emergency condition*, to the nearest *hospital* that can provide *emergency services* appropriate to treat the *member's emergency condition*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.
3. Transportation between *hospitals* or between a *hospital* and a more appropriate level of care when *authorized* by Ambetter Health.
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 Pennsylvania law, if you receive services from non-network ambulance providers, you may be *balance billed*.

Exclusions:

No benefits will be paid for:

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

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

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

Limitations: Benefits for air ambulance services are limited to:

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

Exclusions:

No benefits will be paid for:

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

Autism Spectrum Disorder Benefits

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

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

No limitation exists within the benefits for *applied behavior analysis* services. These services are subject to *prior authorization* to determine medical necessity. If multiple services are provided on the same day by different providers, a separate *copayment* and/or *coinsurance* will apply to each provider. Please refer to the Behavioral Health Treatment: Mental Health Disorder and Substance Use Disorder Services provision of the *Schedule of Benefits* for *cost share* information.

BRCA Screening Coverage

Screening, genetic counseling and testing for BRCA genetic mutations is a *covered service* for adult female *members* with a family history of breast, ovarian, tubal or peritoneal cancer or an ancestry associated with a harmful mutation in the BRCA gene, or who meet any other criteria under which the United States Preventive Services Task Force has recommended screening for a risk of such a mutation, as determined by the *member's PCP*, who have not already undergone such screening.

Chiropractic Services

Chiropractic services are covered when a participating chiropractor finds that the services are *medically necessary* to treat or diagnose neuromusculoskeletal disorders on an *outpatient* basis. *Covered services* are subject to all other terms and conditions of the *policy*, including *deductible amount* and *cost sharing* provisions.

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 who 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.

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

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

1. Phase I and II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and
2. The *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.

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

1. One of the National Institutes of Health (NIH);
2. The Centers for Disease Control and Prevention;
3. The Agency for Health Care Research and Quality;
4. The Centers for Medicare & Medicaid Services;
5. An NIH Cooperative Group or Center;
6. The FDA in the form of an investigational new drug application;

7. The federal Departments of Veterans' Affairs, Defense, or Energy;
8. An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects; or
9. A qualified non-governmental research entity that meets the criteria for NIH Center support grant eligibility.

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

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

Dental Benefits – Adults 19 years of age or older

Coverage for *dental services* is provided for adults, age 19 and older, for diagnostic and preventive, basic services, and major services rendered by dental providers.

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

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

Services not covered:

1. *Dental services* that are not *medically necessary* or specifically covered;
2. Hospitalization or other facility charges;
3. *Prescription drugs* dispensed in the dental office;
4. Any dental procedure performed solely as a cosmetic procedure;
5. Charges for dental procedures completed prior to the *member's effective date* of coverage;
6. Services provided by an anesthesiologist;
7. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing or repairing tooth structure lost by attrition (wear), abfraction, abrasion, or erosion, realignment of teeth, periodontal splinting, and gnathologic recordings;
8. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles;
9. Any artificial material implanted or grafted into soft tissue or bone, surgical removal of implants, and implant-related services;
10. Sinus augmentation;
11. Surgical appliance removal;
12. Intraoral placement of a fixation device;
13. Oral hygiene instruction, *tobacco* counseling, nutritional counseling, or high-risk *substance use disorder* counseling;
14. Services for teeth retained in relation to an overdenture;
15. Any oral *surgery* that includes surgical endodontics (apicoectomy and retrograde filling);
16. Analgesia (nitrous oxide);
17. Temporary procedures;
18. Splinting;
19. Temporomandibular joint (TMJ) disorder appliances, therapy, films and arthrograms;
20. Oral pathology laboratory charges;
21. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
22. Veneers (bonding of coverings to the teeth);
23. Orthodontic treatment procedures;
24. Orthognathic *surgery*;
25. Athletic mouth guards; and
26. Space maintainers.

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 services include, but are not limited to:

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

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

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

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*;
4. Dialysis treatment of an acute or chronic kidney ailment which may include the supportive use an artificial kidney machine.

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

rental price is projected to exceed the equipment purchase price, but only from a provider we *authorize* before the purchase.

Disposable Medical Supplies

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

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.
4. The equipment, supply, or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include the following:

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

We may establish reasonable quantity limits for certain supplies, equipment, or appliance described below. See your *Schedule of Benefits* for benefit levels or additional limits. *Durable medical equipment* and supplies are subject to *prior authorization* as outlined in this *policy*.

Durable Medical Equipment

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

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

1. Hemodialysis equipment;
2. Crutches and replacement of pads and tips;
3. Pressure machines;
4. Artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including *medically necessary* repairs or replacement to restore or maintain a *member's* ability to perform activities of daily living or essential job-related activities;
5. Rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator;
6. Rental of one Continuous Passive Motion (CPM) machine per *member* following a covered joint *surgery*;
7. Infusion pump for IV fluids and medicine;
8. Glucometer;
9. Tracheotomy tube;
10. Cardiac, neonatal, and sleep apnea monitors;
11. Augmentative communication devices are covered when we approve based on the *member's* condition.

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 and supplies may include, but are not limited to:

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

Exclusions:

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

1. Adhesive tape, band aids, cotton tipped applicators;
2. Arch supports;
3. Doughnut cushions;
4. Hot packs, ice bags;
5. Vitamins (except as provided for under Preventive Care 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* and supplies may include, but are not limited to, the following:

1. Cervical collars;

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

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

Exclusions:

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

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

Prosthetics

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

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

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

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

1. Aids and supports for defective parts of the body including, but not limited to, internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.

2. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per benefit period, as required by the Women's Health and Cancer Rights Act. Maximums for *prosthetic devices*, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are *covered services*. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract *surgery* or *injury*; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of *surgery* are not considered contact lenses and are not considered the first lens following *surgery*. If the *injury* is to one eye or if cataracts are removed from only one eye and the *member* selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
7. Restoration prosthesis (composite facial prosthesis).
8. Wigs (not to exceed one per *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: For unanticipated or *emergency services* received in a *network* facility from a *non-network provider*, from the time you present for *emergency services* until the time of discharge you will only be responsible for your standard *cost sharing* amount. *Emergency services* received in a *non-network* facility 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 HRSA:

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

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

Fertility Preservation

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

Habilitation, Rehabilitation, and Extended Care Facility Expense Benefits

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

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

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

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

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

Home Health Care Service Expense Benefits

Covered services and supplies for *home health care* are covered when your *physician* indicates you are not able to travel for appointments to a medical office. Coverage is provided

for *medically necessary network* care provided at the *member's* home and includes the following:

1. *Home health aide services* only if provided in conjunction with skilled registered nurse or licensed practical nursing services.
2. Skilled services of a registered nurse or licensed practical nurse rendered on an *outpatient* basis.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care*. Please refer to your *Schedule of Benefits* for any limits associated with this benefit.
4. Intravenous medication and pain medication.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental of *medically necessary durable medical equipment* at our discretion.

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

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

Limitations:

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

Exclusions:

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

Hospice Care Service Expense Benefits

Hospice care benefits are allowable for a *terminally ill member* receiving *medically necessary* care under a *hospice care program* or in a home setting. *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* under *hospice* care. Respite days that are applied toward the *deductible amount* are considered benefits provided and shall apply against any maximum benefit limit for these services. Benefits for *hospice*, *inpatient*, home and *outpatient* care is subject to *prior authorization* as outlined in this *policy*. See your *Schedule of Benefits* for coverage limits.

Covered services and supplies include:

1. Room and board in a *hospice* while the *member* is an *inpatient*;
2. Occupational therapy;
3. Speech-language therapy;

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

Exclusions and Limitations:

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

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

Hospital Benefits

Covered services 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* to persons for use only while they are *inpatient*s;
7. Emergency treatment of an *injury* or *illness*, even if confinement is not required. See your *Schedule of Benefits* for limitations.

Infertility

Covered services under this benefit are provided for *medically necessary* diagnostic and exploratory procedures to determine infertility. Coverage is also provided for artificial insemination, as well as for *surgical procedures* to correct a medically diagnosed disease or condition of the reproductive organs including, but not limited to, treatment of the following:

1. Endometriosis;
2. Collapsed/clogged fallopian tubes; or
3. Testicular failure.

This benefit is subject to *deductible* and *coinsurance*/*copayment*.

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

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 *policy*.

Common conditions/services that may be considered *medically necessary* for LTACH level of care include, 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.

Lymphedema

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

Mammography

Covered services for a *member* will include mammography screenings that align with USPSTF A and B rated guidelines. This coverage encompasses *medically necessary* preventive and diagnostic mammograms, digital breast tomosynthesis, magnetic resonance imaging (MRI), ultrasounds, and pathology evaluations. Coverage is available to all *members*, regardless of age, when these services are prescribed by a licensed healthcare provider within their professional scope. For further details on this benefit, please refer to the Preventive Care Guide. In accordance with *applicable law*, coverage must be provided for one diagnostic/supplemental breast exam without *cost share* (including magnetic resonance imaging and breast ultrasound). After one, the appropriate *cost share* will apply. **Note**: 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 health care provider obtain *prior authorization* for delivery. An *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require notification to the health plan.

Following early release from an *inpatient* maternity stay, at least one *home health care* service will be provided, at no *cost sharing*, within 48 hours of discharge if:

1. Discharge occurs earlier than 48 hours of a vaginal delivery; or
2. Discharge occurs earlier than 96 hours of a cesarean delivery.

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

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

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

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

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

Duty to Cooperate

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

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

In the event that a *member* fails to comply with this provision, we reserve our right to enforce this provision on the basis of fraud, misrepresentation or false information, up to and including

recoupment of all benefits that we paid on behalf of the *surrogate* during the time that the *surrogate* was insured under our *policy*, plus interest, attorneys' fees, costs and all other remedies available to us.

Newborns' and Mothers' Health Protection Act Statement of Rights

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

Newborn Charges

Medically necessary services, including *hospital* services, are provided for a covered newborn child immediately after birth. Please refer to the Dependent Member Coverage section of this document for details regarding Coverage for a Newborn Child/Coverage for an Adopted Child.

Medical and Surgical Expense Benefits

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

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

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

3. For medical services in an office or facility that is provided by a licensed *medical practitioner* or *specialist physician*, including consultations and *surgery* related services.
4. For elective sterilization procedures (e.g., vasectomies). **Note**: No *cost-share* applies, except for HSA-compatible plans.
5. For chemotherapy (including oral chemotherapy), inhalation therapy, infusion therapy, and radiation therapy or treatment in a *hospital* or office setting.
6. For *durable medical equipment*, *prosthetic devices*, *orthotic devices* or other *necessary medical supplies* following a medical or *surgical procedure* such as crutches, orthopedic splints, braces or casts. Please see the Durable Medical Equipment provision of this *policy*.
7. For hemodialysis and the charges by a *hospital* or facility for the processing and administration of genetic testing, blood or blood components, including cost of blood, blood plasma and blood plasma expanders, which is not replaced by or for you.
8. For the cost and administration of anesthesia, oxygen, drugs, medications and biologicals.
9. For *medically necessary* reconstructive or cosmetic *surgery* including, but not limited to:
    a. Reconstructive breast *surgery* charges as a result of a partial or total mastectomy. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedema.
    b. *Reconstructive surgery* for craniofacial abnormalities.
10. For *medically necessary* dental *surgery* due to:
    a. An accidental *injury* which results in damage to natural teeth. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
    b. *Surgery* to correct a functional defect which results from a congenital and/or acquired disease or anomaly.
    c. Cleft lip and cleft palate for an eligible *member*. *Covered services* include medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the treating *physician* or surgeon and such *physician* or surgeon certifies that such services are *medically necessary* and consequent to treatment of the cleft lip or cleft palate.
    d. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* charges for dental care, rendered by a dentist, provided to the following *members*:

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

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

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

11. For infertility counseling and planning services when provided by a *network* provider and testing to diagnose infertility.
12. For the treatment of breast cancer by dose-intensive chemotherapy bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy bone marrow transplants or stem cell transplants.
13. For routine patient care for *members* enrolled in an eligible cancer clinical trial that is deemed an *experimental* or *investigational* treatment if the services provided are otherwise considered *covered services* under this *policy*. See the Clinical Trial Coverage provision of this *policy*.
14. For the following types of *medically necessary* implants and tissue grafts:
    a. Cornea transplants
    b. Artery or vein grafts
    c. Heart valve grafts
    d. Prosthetic tissue replacement, including joint replacements
    e. Implantable prosthetic lenses, in connection with cataracts
    f. Skin grafts
15. For X-rays, Magnetic Resonance Imaging (MRI), Computed Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT), and other diagnostic services. See Radiology, Imaging and Other Diagnostic Testing provision of this *policy*.
16. For *medically necessary telehealth services*. *Telehealth services* not provided through *Virtual 24/7 Care* would be subject to the same *cost sharing* as the same health care services when delivered to a *member* in person.
17. For *surgery* or services related to cochlear implants and bone-anchored hearing aids.
18. For *medically necessary* services for complications arising from medical and surgical conditions.

19. For respiratory, pulmonary, cardiac, physical, occupational and speech therapy services. Please see Habilitation, Rehabilitation, and Extended Care Facility Expense Benefits provision of this *policy*.
20. For children's early intervention therapy for expenses arising from the services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists and clinical social workers working with children from birth to 36 months of age with an identified developmental disability and/or delay.
21. For *medically necessary* footcare treatment that may require *surgery*; *prior authorization* may be required.
22. For dermatology services which are limited to the following: *medically necessary* minor *surgery*, tests and office visits provided by a dermatologist who is a *network* provider.
23. For *medically necessary* biofeedback services.
24. For abortions performed to save the life of the *member*, consistent with the appropriate determination of the *physician*, or otherwise performed in accordance with *applicable law*.
25. For services associated with human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation or transplant procedures.
26. For *medically necessary chiropractic care* or manipulative therapy treatment on an *outpatient* basis only.
27. 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.
28. For *medically necessary* allergy testing and treatment including allergy injections and serum.
29. For *medically necessary* nutritional counseling; *prior authorization* may be required.
30. For blood lead testing as follows:
    a. In the case of pregnant *members* one blood lead test per *pregnancy* if a single risk factor is identified in accordance with recommendations from the Centers for Disease Control and Prevention and the American College of Obstetricians and Gynecologists.
    b. In the case of *members* who are under two years of age, at least one blood lead test by 24 months of age in accordance with recommendations from the Centers for Disease Control and Prevention and the American Academy of Pediatrics, and, if the result of the blood level test indicates an elevated blood lead level, another blood lead test by venipuncture within 12 weeks of the blood level test in which the elevated blood lead level was indicated.
31. For expenses or services related to immunizations and vaccinations for travel purposes.

32. For *medically necessary* services or treatment for specified sex-trait modification procedures.

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 Foods and Nutritional Services

We cover medical foods and formulas for:

1. *Outpatient* total parenteral nutritional therapy;
2. Nutritional counseling;
3. *Outpatient* elemental formulas for malabsorption; and
4. Dietary formula (when *medically necessary* and prescribed by *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.

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

We also cover nutritional services for the treatment of cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, or kidney disease. Please refer to your *Schedule of Benefits* for applicable *cost sharing* and benefit limitations. Benefits for medical foods are exempt from any *deductible* requirements.

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

Medical Dental Services

Anesthesia and *hospital* charges for *medically necessary* dental care are covered if the *member* requires dental treatment to be given in a *hospital* or *ambulatory surgical center*. 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 to, the following:
    a. Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
    b. Orthognathic *surgery* for a physical abnormality that prevents normal function of the upper and/or lower jawbone and is *medically necessary* to attain functional capacity of the affected part.
    c. Oral/surgical correction of accidental *injuries*.
    d. Treatment for temporomandibular joint (TMJ) disorder, including removable appliances for TMJ repositioning and related *surgery*, medical care, and diagnostic services.
    e. Treatment of non-dental lesions, such as removal of tumors and biopsies.
    f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

g. *Surgical procedures* that are *medically necessary* to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.

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

i. *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.

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.

Excluded services for routine and non-routine vision include:

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 as a result 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.*

Mental Health and Substance Use Disorder Benefits

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

If you need *mental health disorder* or *substance use disorder* treatment, you may choose any provider participating in our *behavioral health network* and do not need a referral from your *PCP* in order to initiate treatment. You can search for *network behavioral health* providers by accessing the “Find a Doctor” page at AmbetterHealth.com/en/PA or by calling Member Services. *Deductible amounts*, *copayment*, or *coinsurance amounts* and treatment limits for covered *behavioral health* benefits will be provided on the same terms and conditions as medical and surgical benefits.

Covered services for the diagnosis and *medically necessary* treatment of *mental health disorders* and *substance use disorders*, as defined in this *policy* 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 disorder* determinations and American Society of Addiction Medicine (ASAM) criteria for *substance use disorder* determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

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

Inpatient

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

Outpatient

1. Partial Hospitalization Program (PHP);
2. Intensive Outpatient Program (IOP);
3. Mental health day treatment;
4. *Outpatient* detoxification programs;
5. Evaluation and assessment for *mental health disorder* and *substance use disorders*;
6. Individual, family, and group therapy for *mental health disorder* and *substance use disorders*;
7. Medication Assisted Treatment – combines *behavioral health* therapy and medications to treat *substance use disorders*;
8. Medication management services;
9. Psychological and neuropsychological testing and assessment;
10. *Applied behavior analysis (ABA)* therapy;

11. Telehealth (individual/family therapy; medication monitoring; assessment and evaluation);
12. Electroconvulsive Therapy (ECT);
13. *Transcranial magnetic stimulation* (*TMS*).

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

Note: Please be aware that some services, addressed in other sections of this *policy*, 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.

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*.

Note: We subclassify our *outpatient mental health disorder* and *substance use disorder* benefits into office visits and other *outpatient services*.

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

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

Pediatric Vision Benefits – Children under the age of 19

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

1. Routine ophthalmological examination
    a. Refraction
    b. Eye evaluation including dilation
2. Standard frames
3. Prescription lenses
    a. Single
    b. Bifocal

c. Trifocal or
d. Lenticular

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

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

Services not covered:

1. Deluxe frame/frame upgrade
2. Visual therapy
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 services in this benefit subsection are limited to charges from a licensed pharmacy for:

1. A *prescription drug*.
2. Prescribed, self-administered anticancer medication.
3. Any drug that, under the *applicable law*, may be dispensed only upon the written prescription of a *physician*.
4. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one Standard Reference Compendium; or
    b. The drug is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

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

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

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

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

Special Rules for Prescription Drug Coverage:

1. The financial requirements applicable to orally administered cancer medications may be no different than those same requirements applied to intravenously administered or injected cancer medications.
2. Coverage for prescribed drugs for certain types of cancer shall not exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration if proper documentation, as outlined, is provided. Such coverage shall also include those *medically necessary* services associated with the administration of such drugs.
3. We will not deny or limit coverage for prescription inhalants when diagnosis is for asthma or other life-threatening bronchial ailments.

Formulary or Prescription Drug List

The formulary or *prescription drug* list is a guide to available generic and brand name drugs and some over-the-counter medications, when ordered by a *physician*, that are approved by the United States 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/en/PA or call Member Services.

For prescription eye drops to treat a chronic eye disease or condition, refills are dispensed on or before the last day of the prescribed dosage period, but not earlier than the following:

1. 21st calendar day after the date a prescription for a 30-calendar day supply of eye drops is dispensed;
2. 42nd calendar day after the date a prescription for a 60-calendar day supply of eye drops is dispensed; or
3. 63rd calendar day after the date a prescription for a 90-calendar day supply of eye drops is dispensed.

Over-the-Counter (OTC) Prescriptions

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

How to Fill a Prescription

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

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

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

Split-Fill Dispensing Program

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

Generic Medication

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.

Medication Balance-On-Hand

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

Mail Order Pharmacy/ Prescription Drug Delivery

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

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.

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 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.

Prescription Drug Exception Process

Standard exception request

A *member*, a *member’s authorized representative* or a *member’s* prescribing *physician* may request a standard review of a decision that a drug is not covered by us or a protocol exception for step therapy. The request can be made in writing or via telephone. Within the lesser of two business days or 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 expedited exception or step therapy protocol exception request be granted, we will provide coverage of the non-formulary drug or the drug that is the subject of the protocol exception for the duration of the exigency.

External exception request review

If we deny a request for a standard exception or for an expedited exception, the *member*, the *member’s authorized representative* or the *member’s* prescribing *physician* may request that the original exception request and subsequent denial of such request be reviewed by an *independent review organization*. We will make our determination on the external exception request and notify the *member*, the *member’s authorized representative* or the *member’s* prescribing *physician* of our coverage determination no later than the lesser of two business days or 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 request 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.

Lock-in program

To help decrease overutilization and abuse, certain *members* identified through our lock-in program, may be locked into a specific pharmacy for the duration of their participation in the lock-in program. *Members* locked into a specific pharmacy will be able to obtain their medication(s) only at specified location. Ambetter pharmacy, together with Medical Management will review *member* profiles and using specific criteria, will recommend *members* for participation in 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 *appeal* rights.

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/coverage/preventive-care-benefits.

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

Certain services can be performed for preventive or diagnostic reasons (e.g., mammograms). If a service is deemed preventive care and is appropriately reported/billed, it will be covered under the preventive care services benefit. However, when a service is performed for diagnostic purposes and reported/billed accordingly, it will be considered a non-preventive medical benefit and appropriate *cost share* will apply. **Note**: If preventive and diagnostic services are performed during the same visit, applicable *cost share* will be taken for the latter. For HSA-compatible plans, the *deductible* cannot be waived for benefits that exceed the federal ACA preventive care requirements.

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

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

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

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

Covered Preventive Services for Adults

The recommended doses, recommended ages, and recommended populations may vary, and are available in the Ambetter Health Preventive Care Guide. Immunization vaccines for adults are covered without *cost share* and include:

1. COVID -19
2. Haemophilus influenza type b (HIB)
3. Hepatitis A
4. Hepatitis B
5. Herpes Zoster
6. Human Papillomavirus (HPV)
7. Influenza (Flu Shot)
8. Measles, Mumps, Rubella
9. Meningococcal

10. Mpox
11. Pneumococcal
12. Poliovirus (inactivated)
13. Respiratory syncytial virus (RSV)
14. Tetanus, Diphtheria, Pertussis
15. Varicella

Covered Preventive Services for Children

The recommended doses, recommended ages, and recommended populations may vary and are available in the Ambetter Health Preventive Care Guide. Immunization vaccines for children from birth through age 18 are covered without *cost share* and include:

1. COVID-19
2. Dengue
3. Diphtheria, Tetanus, Pertussis
4. Haemophilus influenzae type b
5. Hepatitis A
6. Hepatitis B
7. Human Papillomavirus
8. Influenza (Flu Shot)
9. Measles, Mumps, Rubella
10. Meningococcal
11. Mpox
12. Pneumococcal
13. Poliovirus (inactivated)
14. Respiratory syncytial virus (RSV)
15. Rotavirus
16. Varicella

Prostate Specific Antigen Testing

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

Radiology, Imaging and Other Diagnostic Testing

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

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

Second Medical Opinion

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

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

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

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

Sleep Studies

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

Transplant 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 *policy*. *Prior authorization* must be obtained through the "*Center of Excellence*", a *network* facility, or in a *non-network facility* approved by us when there is no *network* adequacy, before an evaluation for 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 *policy* 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 *policy* 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 services* will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting of the organ from the donor.
3. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
4. Including *outpatient covered services* related to the transplant *surgery*; pre-transplant laboratory testing and treatment, such as high dose chemotherapy, peripheral stem cell collection, and other 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.
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/pa/resources/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 *medically necessary* transplant from any *physician*. However, if a *medically necessary* transplant is performed in a *Center of Excellence*:

1. We will pay for the following services when the *member* is required to travel more than 60 miles from their *residence* to the *Center of Excellence*.
2. We will pay for the following services, subject to the maximum identified in the *Schedule of Benefits*:
    a. Transportation for the *member*, any live donor, and the companion(s) to accompany to and from the *Center of Excellence* in the United States.
    b. When the *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.
3. 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 following approved items listed in the *member* transplant reimbursement guidelines. However, you must make the arrangements and provide the necessary paid receipts for reimbursement within six months of the date of service in order to be reimbursed.

Please refer to the Member Resources page for travel reimbursement forms and information at AmbetterHealth.com/en/PA.

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 *policy*:
    a. Alcohol/*tobacco;*
    b. Car, trailer, or truck rental (unless pre-approved by Case Management);
    c. Vehicle maintenance for motorized and hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.);
    d. Parking (unless pre-approved by Case Management);
    e. Storage rental units;
    f. Temporary housing incurring rent/mortgage payments;
    g. Loss of wages due to time off from work required for transplant for recipient, donor, or companion(s);
    h. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.;
    i. Moving violation tickets or parking tickets;
    j. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.);
    k. 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;
    m. Expenses for lodging when the transplant recipient, donor, or their respective companion(s) are staying with a relative, friend, or otherwise have free lodging;
    n. Any expense not supported by a receipt;
    o. Upgrades to first class travel (air, bus, and train);
    p. Personal care items (e.g., shampoo, deodorant, clothes);

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

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

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

t. Any fuel costs/charging station fees for any vehicle (but note that mileage is reimbursable);

u. Any tips, concierge, club level floors, and gratuities;

v. Salon, barber, and spa services;

w. Insurance premiums;

x. *Cost share* amounts owed to the transplant surgeon or facility or other provider.

Urgent Care

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

Members are encouraged to contact their *PCP* for an appointment before seeking care from another provider, but contracted *urgent care centers* and walk-in clinics can be used when an urgent appointment is not available. If the *PCP* is not available and the condition persists, call the 24/7 Nurse Advice Line at 1-833-510-4727 (Relay 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.

Vision Benefits – Adults 19 years of age or older

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

1. Routine ophthalmological examination
    a. Refraction
    b. Eye evaluation including dilation
2. Frame(s)
3. Prescription lenses
    a. Single
    b. Bifocal
    c. Trifocal
    d. Lenticular
4. Contact lenses and contact lens fitting (in lieu of glasses)

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

Services not covered:

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

WELLNESS PROGRAMS AND OTHER OFFERINGS

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

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

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

You can access other services in connection with this *policy*, such as the “Ambetter Perks” program, which offers discounts on a wide range of activities, services, goods, financial tools, memberships, out-of-pocket prescription expenses, over-the-counter (OTC) health products, and health- and wellness-related services addressing *social determinants of health* and healthy lifestyle. *Members* are responsible for paying for the discounted goods or services and we do not endorse any vendor, goods or services associated with the program. *Members* may also have access to a zero-interest line of credit through the Ambetter Perks program for paying their *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, fees, taxes, or surcharges imposed on the *member* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.
3. Any services performed by a *member* of the *member's immediate family*.
4. Any services not identified and included as *covered services* under the *policy*. You will be fully responsible for payment for any services that are not *covered services*.
5. Any services where other coverage is primary to Ambetter must be first paid by the primary payor prior to consideration for coverage under Ambetter.

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*.
2. For any portion of the charges that are in excess of the *eligible expense*.
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*, and bariatric *surgery*, except as specifically covered in the Major Medical Expense Benefits section of the *policy*.
4. For weight loss programs, gym memberships, exercise equipment, or meal preparation programs.
5. For the reversal of elective sterilization procedures.
6. For abortions, unless performed to save the life of the *member*, consistent with the appropriate determination of the *physician*, or otherwise not illegal under *applicable law*.
7. For treatment of malocclusions disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered services* of the Major Medical Expense Benefits provision.
8. For expenses for television, telephone, or expenses for other persons.
9. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.

10. For telephone consultations between providers, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
11. For stand-by availability of a *medical practitioner* when no treatment is rendered.
12. For *dental service* expenses, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits.
13. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect.
14. For *mental health disorder* examinations and services involving:
    a. School funded/administered services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
    b. Pre-marital counseling;
    c. Court-ordered care or testing or required as a condition of parole or probation. Benefits will be allowed for services that are *medically necessary* and would otherwise be covered under this *policy*;
    d. Testing of aptitude, ability, intelligence or interest; and
    e. Evaluation for the purpose of maintaining employment. Benefits will be allowed for services that would otherwise be covered under this *policy*.
15. For Assertive Community Treatment (ACT).
16. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
17. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
18. For *members* while confined primarily to receive *rehabilitation*, *custodial care*, educational care, or nursing services (unless expressly provided for in this *policy*).
19. For vocational or recreational therapy, vocational *rehabilitation*, *outpatient* speech therapy, or occupational therapy, except as expressly provided for in this *policy*.
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 *policy*.
21. For hearing aids, except as expressly provided in this *policy*.
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. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to *applicable law*. If you enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's* workers' compensation claim, this exclusion will still apply unless that denial is *appealed* to the proper governmental agency and the denial is upheld by that agency.
24. For fetal reduction *surgery*.
25. Except as specifically identified as a *covered service* under the *policy*, services or expenses for alternative treatments, including acupressure, 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.
26. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or participating with others in any of the following: professional or semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); racing or speed testing any Non-motorized vehicle or conveyance (if the *member* is paid to participate or to instruct); rodeo sports; horseback riding (if the *member* is paid to participate or to instruct); rock or mountain climbing (if the *member* is paid to participate or to instruct); or skiing (if the *member* is paid to participate or to instruct).
27. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or *member* of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
28. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
29. For the following miscellaneous items: Blood and blood products; care or complications resulting from non-covered services; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods provision; 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; private duty nursing; *rehabilitation* services for the enhancement of job, athletic, or recreational performance; routine or elective care outside the *service area*; treatment of spider veins; transportation expenses, unless specifically described in this *policy*.
30. For diagnostic testing, laboratory procedures screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
31. For any non-medically necessary court ordered care for a medical/surgical or *mental health disorder*/*substance use disorder* diagnosis, unless required by state law.

32. For a *member's illness* or *injury* which is caused by the acts or omissions of a *third-party*, we will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third-party*.
33. For any medicinal or recreational use of cannabis or marijuana.
34. For all health care services obtained at an *urgent care center* that is a *non-network provider*.
35. 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.
36. For expenses, services, and treatments from a naturopathic specialist for treatment of prevention, self-healing and use of natural therapies.
37. For a *surrogacy arrangement*. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or using the services of a *surrogate* who may or may not be a *member,* 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 disorder* services related to the *surrogacy arrangement*;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
    h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement*, 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 *surrogacy arrangement*; or
    m. Any other medical or healthcare services related to the *pregnancy* or preparations to become a *surrogate* or donor.

    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 has an active *policy* with us effective at the time of birth.

38. 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.
39. For doula services.
40. For expenses or services related to immunizations and vaccinations for occupational purposes.

TERMINATION

Termination of Policy

All coverages will cease on termination of this *policy*. This *policy* will terminate on the earliest of:

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *policy*;
2. The date we receive a request from you to terminate this *policy*, or any later date stated in your request, or if you are enrolled through the Exchange, the date of termination that the Exchange provides us upon your request of cancellation to the Exchange;
3. The date we decline to renew this *policy*, as stated in the Discontinuance provision;
4. The date of your death, if this *policy* is an individual plan;
5. For a covered *eligible child* reaching the limiting age of 26, coverage under this *policy* will terminate at 11:59 p.m. on the last day of the year in which the *eligible child* turns 26;
6. The date a *member's* eligibility for coverage under this *policy* ceases due to any of the reasons stated in the Eligibility and Enrollment section in this *policy*; or
7. The date a *member's* eligibility for coverage under this *policy* ceases as determined by the Exchange.

Refund upon Cancellation

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

Reinstatement

In the event that this *policy* lapses due solely to nonpayment of premium, an enrollment application is required for reinstatement. If premium is received from the *member* with an enrollment application, we shall issue a conditional receipt for the premium paid and the *policy* shall be reinstated upon approval of the enrollment application, or lacking such approval, on the 45th calendar day following the date of conditional receipt, unless we have previously notified the *member* in writing of our disapproval of the enrollment application. Once the *policy* is reinstated, *losses* resulting from accidental *injury* shall be covered, while *loss* due to *illness* will be covered after ten calendar days from that reinstatement date. In addition, the *member* and Ambetter shall have the same rights as they had under the *policy* before the due date of

the defaulted premium. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 calendar days prior to the date of reinstatement.

Discontinuance

90-Day Notice:

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

180-Day Notice:

If we discontinue offering all individual policies in the individual market in the state where you reside, we will provide a written notice to you and the Commissioner of Insurance at least 180 calendar days prior to the date that we stop offering and terminate all existing individual policies in the individual market in the state where you reside.

SUBROGATION AND RIGHT OF REIMBURSEMENT

Any *injuries* to or *illness* of a *member* that is, may be, or is claimed to be caused by a *third-party* are referred to as "*third-party injuries*". "Responsible party" includes any parties actually, possibly or potentially responsible for payment of expenses associated with the care or treatment of *third-party injuries*.

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

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

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

By accepting benefits under this plan, the *member* also specifically acknowledges Ambetter Health's right of reimbursement. This right of reimbursement attaches, to the fullest extent permitted by law, when this plan has provided health care benefits for expenses incurred due to *third-party injuries* or *illness* for which a *third-party* is liable, and the *member* or the *member's* representative has recovered any amounts from any source. By providing any benefit under this plan, Ambetter Health is granted an assignment of the proceeds of any settlement, judgment or other payment received by the *member* to the extent of the full cost of all benefits provided by Ambetter Health. Ambetter Health's right of reimbursement is cumulative with and not exclusive of Ambetter Health's right of subrogation and Ambetter Health may choose to exercise either or both rights of recovery.

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

1. To fully cooperate with us in order to obtain information about the *loss* and its cause and do whatever is necessary to secure the plan's rights of reimbursement or subrogation.

2. To immediately inform us in writing when notice is given to any *third-party* of the intention to investigate or pursue a claim to recover damages or obtain compensation due to *injuries* or *illness* sustained by the *member* that may be the legal responsibility of a *third-party*.
3. To include the amount of benefits paid by us on behalf of a *member* in any claim made against any *third-party*.
4. That we:
    a. Will have the right to intervene in any suit or legal action to protect our rights.
    b. Are entitled to all of the rights of the *member* against any *third-party* to the extent of the benefits paid on the *member's* behalf.
    c. May assert the right of subrogation independently of the *member*.
5. To take no action that prejudices our reimbursement or subrogation rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan.
6. To sign, date, and deliver to us any documents we request that protect our reimbursement rights.
7. To not settle any claim or lawsuit against a *third-party* without providing us with written notice of the intent to do so.
8. To reimburse us from the full compensation received from any *third-party* to the extent of benefits we paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third-party*'s payment is expressly designated as a payment for medical expenses.
9. Give the plan a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with *third-party injuries* provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
10. Pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, any and all amounts due to the plan as reimbursement for the full cost of all benefits associated with *injuries* or *illness* provided by the plan for which a *third-party* is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement).

We may recover the full cost of all benefits provided under this plan regardless of whether you are fully compensated or made whole for your *losses*.

We may recover the full cost of all benefits provided under this plan without regard to any claim of fault on the part of the *member*, whether by comparative negligence or otherwise.

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

COORDINATION OF BENEFITS

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

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

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

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

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

The term "plan" includes group and non-group insurance contracts, Health Maintenance Organization (HMO) contracts, closed panel plans or other forms of group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

The term "plan" does not include *hospital* indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

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

Order of Benefit Determination Rules

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

1. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. A plan may consider benefits paid or provided by another plan in determining its benefits only when it is secondary to that *other plan*.
2. If the *other plan* does not contain a coordination of benefits provision that is consistent with this provision, then the *other plan* is always primary. There are two exceptions:
    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the policyholder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987, which provides excess major medical benefits intended to supplement any basic benefits on a *member* may continue to be excess to such basic benefits.
3. The first of the following rules that describe which plan pays its benefits before another plan is the rule to use:
    a. **Non-Dependent or Dependent**. The plan that covers the person other than as a *dependent member*, for example as an employee, *member*, policyholder, *subscriber* or retiree is the primary plan and the plan that covers the person as a *dependent member* is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a *dependent member*; and primary to the plan covering the person as other than a *dependent member* (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, *member*, policyholder, *subscriber* or retiree is the secondary plan and the *other plan* is the primary plan.
    b. **Dependent Child Covered Under More Than One Plan**. Unless there is a court decree stating otherwise, when a *dependent member* child is covered by more than one plan the order of benefits is determined as follows:
        i. If a child is covered under the plans of both parents and the parents are not separated or divorced:
            A. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
            B. If both parents have the same birthday, the plan which covered the parent longer will be primary.

ii. If a child is covered by both parents' plans and the parents are separated or divorced, whether or not they have ever been married:

A. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree;

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

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

D. If there is no court decree between the parents that establishes financial responsibility for the child's health care expenses or coverage, the order of benefits for the child are as follows:

a) The plan of the custodial parent;

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

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

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

iii. For a *dependent member* covered under more than one plan of individuals who are the parents of the child, the provisions of subparagraphs (i) or (ii) above shall determine the order of benefits as if those individuals were the parents of the child.

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

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

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

If the amount of the payments made by this plan is more than we should have paid under this COB provision, 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*. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

CLAIMS

Notice of Claim

We must receive notice of claim within 20 calendar days after the occurrence or commencement of any *loss* covered by this *policy*, or as soon as reasonably possible. Notice given by or on behalf of the *member* or the beneficiary to the *member* at P.O. Box 5010, Farmington, MO 63640-5010, or to any authorized agent of the *member*, with information sufficient to identify the *member*, shall be deemed notice to us.

Claim Forms

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

Proof of Loss

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

How to Submit a Claim

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

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

To request reimbursement for a *covered service*, you need a copy of the detailed claim from your provider. You also need to submit an explanation of why you paid for the *covered services* along with the Member Reimbursement Medical Claim Form posted at AmbetterHealth.com/en/PA. Send all the documentation to us at the following address:

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

Cooperation Provision

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

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

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

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

Time for Payment of Claims

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

Payment of Claims

Except as set forth in this provision, all benefits are payable to you. Any accrued benefits unpaid at your death, or your *dependent member's* death may, at our option, be paid either to the beneficiary or to the estate. If any benefit is payable to your or your *dependent member's* estate, or to a beneficiary who is a minor or is otherwise not competent to give valid release, we may pay up to $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 *policy* for *hospital*, surgical, nursing, or medical services, directly to the *hospital* or other person rendering such services.

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

Time Limit on Certain Defenses

After three years from the date of issue of this *policy*, no misstatements, except fraudulent misstatements, made by the applicant in the enrollment application for such *policy* shall be used to void the *policy* or to deny a claim for *loss* incurred or disability commencing after the expiration of such three-year period. No claim for *loss* incurred or disability commencing after three years from the date of issue of this *policy* shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of *loss* had existed prior to the *effective date* of coverage of this *policy*.

Claims Incurred for Emergency Services While Traveling Outside the United States

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

Claims incurred outside of the United States for *emergency services* must be submitted within 180 calendar days from the date of service. The claims must include clinical documentation (medical records) that supports all *emergency services* received. Claims and medical records must be submitted in English or with an English translation, at the *member's* expense to show proper *proof of loss* and evidence of payment(s) to the provider. Proof of departure from and arrival to the United States must be submitted with the claim.

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

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

Medicaid Reimbursement

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

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

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

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

Custodial Parent

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

Upon request by the custodial parent, we will:

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

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

Physical Examination

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

Legal Actions

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

Non-Assignment

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

No Third-Party Beneficiaries

This *policy* 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 *policy* shall not be construed to create any *third-party* beneficiary rights.

GRIEVANCE AND APPEAL PROCEDURES

Internal Procedures

Applicability/Eligibility

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

Grievances

A *grievance* is a dispute or objection by a *member* (or a *member's authorized representative*) regarding a participating health care provider, or the coverage (including contract exclusions and non-covered services), operations or management policies of Ambetter, which has not been resolved by other means. A *grievance* is not an *appeal*.

Basic elements of a *grievance* include:

1. The complainant is the *member* or an *authorized representative* of the *member*;
2. The submission may or may not be in writing;
3. The issue may refer to any dissatisfaction about:
    a. Us, as the insurer; e.g., customer service *complaints* - "the person to whom I spoke on the phone was rude to me";
    b. Providers with whom we have a direct or indirect contract;
        i. Lack of availability and/or accessibility of *network providers* not tied to an unresolved benefit denial; and
        ii. Quality of care/quality of service issues.

Appeals

An *appeal* is a written request by a *member* (or a *member's authorized representative* or a health care provider with the written consent of the *member*) to have Ambetter reconsider a decision solely concerning the medical necessity and appropriateness of a health care service about any of the following:

1. Disapproves full or partial payment for a requested health service;
2. Approves the provision of a requested health care service for a lesser scope or duration than requested;
3. Disapproves payment of the provision of a requested health care service but approves payment for the provision of an alternative health care service. An *appeal* does not include a *grievance*.

An eligible grievant is:

1. A *member*;

2. A person authorized to act on behalf of the *member*. **Note**: Written authorization is required for another person or a health care provider to file an *appeal* on a *member's* behalf;
3. A *spouse*, family member, or the treating provider; or in the event the claimant is unable to give consent;
4. A person for whom the *member* has verbally given authorization to represent the claimant in the event of an expedited *appeal.*

Grievances and Appeals

Claimants have the right to submit written comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process.

Claimants should submit all documentation to us at:

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

Grievances and *appeals* will be promptly investigated and presented to the internal *grievance* and *appeals* panel. A *policy* that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. We are required to provide continued coverage pending the outcome of an *appeal*.

We offer a one-level internal *appeal* process and a two-level internal *grievance* process.

1. A request for an *appeal* must be submitted within 180 calendar days following receipt of an *adverse benefit determination*.
2. A request for a first-level review of a *grievance* can be submitted at any time.
3. A request for a second level review of a *grievance* decision must be submitted orally or in writing by a *member* or a *member's authorized representative* within 180 calendar days' notice of the first level *grievance* decision. A *grievance* may also be submitted in writing by *member's* provider acting on the *member's* behalf with proper authorization of representation.

Resolution Timeframes

1. All first level *grievance* reviews will be resolved within 30 calendar days of receipt.
2. All second level *grievance* reviews will be resolved within 45 calendar days of the receipt of the *member's* request for a second level review.
3. *Appeals* solely concerning medical necessity will be resolved and we will notify the claimant in writing with the *appeal* decision within the following timeframes:

a. Post-service claim: within 30 calendar days after receipt of the claimant's request for internal *appeal*; or

b. Pre-service claim: within 30 calendar days after receipt of the claimant's request for internal *appeal*.

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

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

Acknowledgement

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

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

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

4. A written acknowledgement of the request for a Second Level Grievance Review shall be provided to the *member* including the name, address, and telephone number of the person coordinating the review, explanation of the process and instructions on submitting written material, including the address to which the material may be submitted. The acknowledgement shall also notify the *member* and/or *member's* representative of their right to appear before the review committee and provide a seven-calendar day advance notice of the date and time scheduled for that review.

Right to Appear

The claimant who filed the *grievance* or *appeal*, or the claimant's *authorized representative*, does not have the right to appear in person before the first level internal review panel.

The claimant who filed the *grievance*, or the claimant's *authorized representative*, has the right to appear in person before the review panel to present written or oral information during the internal 2nd level review. The grievant may submit written questions to the person or persons responsible for making the determination that resulted in the *grievance*.

1. Written notification must be sent to the claimant indicating the time and place of the review panel meeting at least 15 calendar days before the meeting; and
2. Reasonable accommodations must be provided to allow the claimant, or the claimant's *authorized representative*, to participate in the review panel.

Review Committee

Review Committee First Level Complaint: The first level complaint review shall be performed by an initial review committee which will include one or more employees of the plan. The individuals of the committee may not have been involved in a prior decision to deny the *member's* complaint. The committee, however, may consult with the initial decision-maker.

Second Level Complaint: The second level complaint review shall be performed by a second level review committee made up of three or more individuals who did not participate in the matter or initial review. Additional requirements for the committee include:

1. At least one third of the second level review committee may not be employees of the plan or of a related subsidiary or affiliate.
2. The individuals on the second level review committee will have the duty to be unbiased or neutral in the committee's review and decision.

Grievance Review: The *grievance* review shall be performed by a review committee which will include one or more individuals selected by the plan. The individuals of the committee may not have been involved in any prior decision relating to the *grievance*. The *grievance* review shall include a licensed *physician* or an approved licensed psychologist, in the same or similar specialty as that which would typically manage or consult on the health care service in question.

Expedited Appeal

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

An *expedited appeal* shall be resolved as expeditiously as the claimant's health condition requires but not more than 48 hours after receipt of the *appeal*.

Due to the 48-hour resolution timeframe, the standard requirements for notification, and acknowledgement do not apply to *expedited appeals*.

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

Written Grievance and Appeal Response

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

The panel's written decision to the grievant must include:

1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *grievance* or *appeal*;
3. The signature of one voting member of the panel; and
4. A written description of position titles of panel members involved in making the decision.
5. If upheld or partially upheld, it is also necessary to include:
    a. A clear explanation of the decision;
    b. Reference to the specific *policy* provision on which the determination is based;
    c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant 's claim for benefits;
    d. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
    e. If the *adverse benefit determination* is based on a medical necessity or *experimental* treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *policy* to the claimant 's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

f. Identification of medical experts whose advice was obtained on our behalf, without regard to whether the advice was relied upon in making the *adverse benefit determination*;

g. The date of service;

h. The health care provider's name;

i. The claim amount;

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

k. Our denial code with corresponding meaning;

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

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

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

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

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

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

Complaints Received from the State Insurance Department

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

External Review

An *external review* decision is binding on us. An *external review* decision is binding on the claimant except to the extent the claimant has other remedies available under *applicable law*. We will pay for the costs of the *external review* performed by the *independent review organization (IRO)*.

Applicability/Eligibility

The *external review* procedures apply to:

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

After exhausting the internal *grievance* process, the *member* has four months to make a written request to the Pennsylvania (PA) Insurance Department to request an *external review*

after the date of receipt of an *adverse benefit determination* or *final adverse benefit determination.*

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

External review is available for *appeals* that involve:

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

External Review Process

1. We have five business days (immediately for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether:
    a. The individual was a *member* at the time the item or service was requested;
    b. The service is a *covered service* under the claimant's *policy* but for our *adverse benefit determination* with regard to medical necessity *experimental*/*investigational*, or medical judgment;
    c. The claimant has exhausted the internal process; and

d. The claimant has provided all of the information required to process an *external review*.

2. Within one business day (immediately for expedited) after completion of the preliminary review, we will notify the claimant in writing as to whether the request is complete but not eligible for *external review* and the reasons for its ineligibility or, if the request is not complete, the additional information needed to make the request complete;
3. We must allow a claimant to perfect the request for *external review* within the four-month filing period or within the 48-hour period following the receipt of notification;
4. We will assign an *IRO* on a rotating basis from our list of contracted *IROs*;
5. Within five business days after the date of assignment of the *IRO* (or next business day for expedited cases), we must provide the documents, and any information considered in making the *adverse benefit determination* to the *IRO*. **Note**: For expedited, after assignment of the *IRO*, we must provide the documents, and any information considered in making the *adverse benefit determination* to the *IRO* electronically or by telephone or facsimile or any other available expeditious method;
6. If we fail to timely provide the documents and information, the *IRO* may terminate the *external review* and make a decision to reverse the *adverse benefit determination*;
7. Within five business days, the assigned *IRO* will timely notify the claimant in writing of the request's eligibility and acceptance for *external review*. The notice will include a statement that the claimant may submit in writing additional information to the *IRO* to consider;
8. Upon receipt of any information submitted by the claimant, the *IRO* must forward the information to us within one business day;
9. Upon receipt of the information, we may reconsider our determination. If we reverse our *adverse benefit determination*, we must provide written notice of the decision to the claimant and the *IRO* within one business day after making such decision. The *external review* would be considered terminated;
10. Within 45 calendar days (72 hours for expedited) after the date of receipt of the request for an *external review* by us, the *IRO* will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to the claimant and to us. If the notice for an expedited review is not in writing, the *IRO* must provide written confirmation within 48 hours after the date of providing the notice; and
11. Upon receipt of a notice of a decision by the *IRO* reversing the *adverse benefit determination*, we will approve the *covered service* that was the subject of the *adverse benefit determination*.

Note: Certain *adverse benefit determinations* based on eligibility, incomplete information, or noncompliance with administrative requirements, as well as *rescission* decisions, are not eligible for *external review* by an *independent review organization* (*IRO*). These decisions may be *appealed* to the Pennsylvania Insurance Department within 15 calendar days of receipt of the adverse internal *appeal* decision.

Appeals and Grievances Filing and Key Communication Timelines

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard Grievance	N/A	5 business days	30 calendar days	14 calendar days
Second-Level Grievance Committee	180 calendar days	5 business days	30 calendar days	30 calendar days
Standard Pre-Service Appeal	180 calendar days	5 business days	30 business days	N/A
Expedited Pre-Service Appeal	180 calendar days	N/A	48 hours	N/A
Standard Post-Service Appeal	180 calendar days	5 business days	30 business days	N/A
Pre-Service Second-Level Review	180 calendar days	5 business days	45 days from receipt	N/A
Post-Service Second-Level Review	180 calendar days	5 business days	45 days from receipt	N/A
External Review	4 months	5 business days	60 days from acceptance	N/A
Expedited External Review	4 months	N/A	48 hours	N/A

GENERAL PROVISIONS

Entire Policy

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

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

Non-Waiver

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

Rescissions

No misrepresentation of fact made regarding a *member* during the 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.

Repayment for Fraud, Misrepresentation or False Information

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

Conformity with Applicable Laws

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

Personal Health Information (PHI)

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

We protect all oral, written and electronic PHI. We follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. We are required to notify you about these practices every year. This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. If you need more information or would like the complete notice, please visit AmbetterHealth.com/en/pa/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 do not speak or understand the language in your area, you have the right to an interpreter. For language assistance, please visit AmbetterHealth.com/en/pa/language-assistance.html.