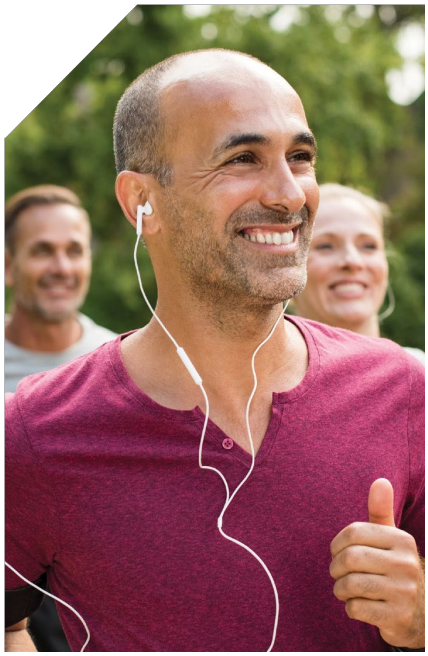
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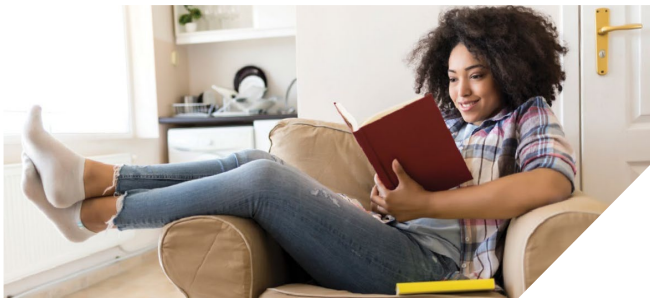




2027 EVIDENCE OF COVERAGE

Ambetter Health





AmbetterHealth.com/en/OH

41047OH001-2027

Ambetter from Buckeye Health Plan

Individual Health Benefit Plan

Issued and underwritten by Buckeye Community Health Plan, Inc.

Home Office: 4349 Easton Way, Suite 120, Columbus, OH, 43219

Individual Member Contract

In this *contract*, the terms “you” or “your” will refer to the *member* or any dependents enrolled in this *contract*. The terms “we”, “our”, or “us” will refer to Ambetter from Buckeye Health Plan.

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

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

Annually, we will change the rate table used for this *contract* form. Each premium will be based on the rate table in effect on that premium's due date. The policy plan, and age of *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 after filing and approval by the state however, all premium rates charged will be guaranteed for a calendar year.

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

Referrals are not required for you to access a *specialist physician* or *other practitioner* (not your *primary care physician (PCP)*) care within the *network*. Referrals for non-network services must always be reviewed by the health plan for *medical necessity* determination and *network provider* availability for benefits to be payable under your *contract* or benefits payable under this *contract* will be denied. Non-network services

are not covered unless *prior authorization* is received, or services are covered under the federal No Surprises Act.

This *contract* is not a Medicare supplement *contract*. If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from the company.

COORDINATION OF BENEFITS

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND *HOSPITALS*, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY *OTHER PLAN* THAT COVERS YOU OR YOUR FAMILY.

RIGHT TO RETURN CONTRACT

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



Justin Loudon,
CEO and Plan President

TABLE OF CONTENTS

INTRODUCTION **9**
How To Contact Us 9
Interpreter Services 9
MEMBER RIGHTS AND RESPONSIBILITIES **10**
IMPORTANT INFORMATION **14**
Provider Directory 14
Member Identification Card 14
Website 15
Quality Improvement 15
Protection from Balance Billing 16
DEFINITIONS **17**
DEPENDENT MEMBER COVERAGE **37**
Dependent Member Eligibility 37
Effective Date for Initial Dependent Members 37
Adding a Newborn Child 37
Adding an Adopted Child 37
Adding Other Dependent Members 38
ELIGIBILITY AND ENROLLMENT **39**
For All Covered Persons 39
For Dependent Members 39
Out of Service Area Dependent Member Coverage 40
Open Enrollment 40
Special Enrollment 40
Coverage Effective Dates for Special Enrollment Periods 42
Prior Coverage 43
PREMIUMS **44**
Premium Payment 44
Grace Period 44
Third-Party Payment of Premiums or Cost Sharing 44
Misstatement of Age 45
Change or Misstatement of Residence 45
Misstatement of Tobacco or Nicotine Use 45
Health Savings Account (HSA) 45

UTILIZATION MANAGEMENT 47
Authorization Requirements 47
How to Obtain Prior Authorization 48
Electronic Procedure 48
Failure to Obtain Prior Authorization 49
Authorization Does Not Guarantee Benefits 49
Requests for Predeterminations of Benefits 49
Services from Non-Network Providers 50
Appeal of Authorization Denial 50
COST SHARING FEATURES 51
Cost Sharing Features 51
Deductible 51
Copayments 51
Coinsurance 51
Maximum Out-of-Pocket 52
Non-Network Liability and Balance Billing 52
ACCESS TO CARE 53
Primary Care Physician (PCP) 53
Contacting Your Primary Care Physician (PCP) 54
Changing Your Primary Care Physician (PCP) 54
Network Availability 54
Service Area 55
Coverage Under Other Policy Provisions 55
Emergency Services 55
Non-Emergency Services 56
Hospital Based Providers 56
Emergency Services Outside of Service Area 56
New Technology 56
Preferred Partnership 56
Continuity of Care 57
MEDICAL SERVICE AND SUPPLY BENEFITS 58
Acquired Brain Injury Services 58
Ambulance Services 59
Autism Spectrum Disorder Benefits 60
Breast Cancer Screenings 61

Care Management Programs 61
Chiropractic Services 62
Clinical Trial Coverage 62
Diabetic Care 64
Dialysis Services 64
Durable Medical Equipment, Medical and Surgical Supplies, Orthotic Devices, and Prosthetics 65
Emergency Services 70
Family Planning and Contraception Services 70
Fertility Preservation 71
Habilitation Expense Benefits 72
Home Health Care Service Expense Benefits 72
Hospice Care Service Expense Benefits 74
Hospital Benefits 75
Long Term Acute Care 75
Infertility 76
Lymphedema Benefit 77
Mastectomy Benefits 77
Maternity Coverage 77
Medical and Surgical Expense Benefits 79
Medical Dental Services 83
Medical Foods 84
Medical Vision Services 85
Mental Health and Substance Use Disorder Benefits 85
Opioid Treatment 87
Pediatric Vision Benefits – Children under the age of 19 88
Prescription Drug Expense Benefits 89
Preventive Care Expense Benefits 95
Prostate Specific Antigen Testing 100
Radiology, Imaging and Other Diagnostic Testing 100
Rehabilitation and Skilled Nursing Facility Expense Benefits 100
Second Medical Opinion 101
Sleep Studies 101
Transplant Expense Benefits 102
Urgent Care Service Benefits 105

WELLNESS PROGRAMS AND OTHER OFFERINGS....106
GENERAL NON-COVERED SERVICES AND EXCLUSIONS....107
TERMINATION....112
Termination of Contract....112
Refund Upon Cancellation....112
Discontinuance....112
Notification Requirements....112
RIGHT OF REIMBURSEMENT....113
COORDINATION OF BENEFITS....115
CLAIMS....121
Notice of Claim....121
Proof of Loss....121
How to Submit a Claim....121
Cooperation Provision....121
Time for Payment of Claims....121
Payment of Claims....122
Claims Incurred for Emergency Services While Traveling Outside the United States....122
Assignment....122
Custodial Parent....123
Physical Examination....123
Personal Health Information (PHI)....123
Language Assistance....123
Legal Actions....124
Non-Assignment....124
No Third-Party Beneficiaries....124
APPEALS AND GRIEVANCE PROCEDURES....125
Call Member Services....125
Appeals Procedures....125
Filing an Appeal....125
Processing Your Appeal....125
Expedited Appeal....126
External Review....126
Filing a Grievance....129
Appeals and Grievances Filing, External Review, and Key Communication Timelines....131
GENERAL PROVISIONS....132

Entire Contract 132
Non-Waiver 132
Rescissions 132
Repayment for Fraud, Misrepresentation, or False Information 132
Conformity with Applicable Laws 133
Hold Harmless 133

INTRODUCTION

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

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

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

How To Contact Us

Ambetter from Buckeye Health Plan
4349 Easton Way, Suite 120
Columbus, OH 43219

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

Member Services:..... **1-877-687-1189**
TTY line: **1-877-941-9236**
Fax:..... **1-877-941-8076**
Emergency: **911**
Suicide and Crisis Lifeline. **988 (call or text)**
24/7 Nurse Advice Line:.... **1-877-687-1189**

Interpreter Services

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

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

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting you as a *member*.
2. Encouraging open discussions between you, 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, and/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/OH.

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 *contract*, regardless of the cost. You have a right to know about any costs you will need to pay. This should be told to you in words you can understand. When it is not appropriate to give you information for medical reasons, the information can be given to a legally *authorized representative*. Your provider will ask for your approval for treatment unless there is an emergency, and your life and health are in serious danger.
8. Voice *complaints* or *appeals* about our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
9. See your medical records.
10. Be kept informed of covered and non-covered services, program changes, how to access services, *PCP* assignment, providers, advance directive information, referrals and *prior authorizations*, benefit denials, *member* rights and responsibilities, and our other rules and guidelines. We will notify you at least 60 calendar days before the *effective date* of the modifications. Such notices shall include the following:
    a. Any changes in clinical review criteria; and
    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*. A listing of *network providers* is available online at AmbetterHealth.com/en/OH. You can find any of our *network providers* by visiting our website and accessing the “Find a Doctor” page. You can also get information on your *network providers’* education, training, and practice.
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, and/or expected health or genetic status.
14. Access *medically necessary emergency services* 24 hours a day, seven days a week.
15. Access *medically necessary* urgent care through *network providers* 24 hours a day, seven days a week, including our 24/7 Nurse Advice Line.
16. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.
17. Refuse treatment to the extent the law allows without jeopardizing future treatment and be informed by your provider(s) of the medical consequences. You are responsible for your actions if treatment is refused or if the *PCP’s* instructions are not followed. You should discuss all concerns about treatment with your *PCP*. Your *PCP* can discuss different treatment plans with you, if there is more than one option that may help you. You will make the final decision.

18. Select your *PCP* within the *network*. You also have the right to change your *PCP* or request information on *network providers* close to your home or work.
19. Know the name and job title of people giving you care. You also have the right to know which provider is your *PCP*.
20. An interpreter when you do not speak or understand the language of the area.
21. A second opinion by a *network provider*, if you want more information about your treatment or would like to explore additional treatment options.
22. Make advance directives for health care decisions. This includes planning treatment before you need it. 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 *contract*.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about your health that we or your *medical practitioners* need in order to provide care. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your provider 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 provider and call the provider’s office during office hours whenever possible if you have a delay or cancellation.
6. Know the name of your assigned *PCP*. You should establish a relationship with your provider. You may change your *PCP* verbally or in writing by contacting Member Services.
7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
8. Understand your health problems and participate, along with your healthcare professionals and providers 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 providers.

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 of any enrollment related changes that would affect your *contract* within 60 calendar days of the event. Enrollment related changes include the following: birth of a child, adoption, marriage, divorce, change of address, adding/removing a dependent, *spouse*/domestic partner becomes eligible under a different insurer or incarceration where *member cost share* would need to transfer from one *contract* to another *contract*.

IMPORTANT INFORMATION

Provider Directory

A listing of *network providers* is available online at AmbetterHealth.com/en/OH. We have *network providers*, *hospitals*, and other *medical practitioners* who have agreed to provide you health care services. You can find any of our *network providers* by accessing the "Find a Doctor" page on our website and selecting the Ambetter Network. There you will have the ability to narrow your search by provider specialty, zip code, gender, languages spoken and whether or not they are currently accepting new patients and languages spoken. Your search will produce a list of providers based on your search criteria and will give you other information such as name, address, phone number, office hours, and qualifications, specialty and board certifications.

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

If you receive services from a *non-network provider* because of inaccurate information in the provider directory or in response to an inquiry about *network* status, please contact Member Services. If the services you received are otherwise *covered services*, you will only be responsible for paying the *cost sharing* that applies to *network providers* and should not be *balance billed* by the *non-network provider*. See *balance billing*, *balance billing protections*, and *non-network provider* definitions for additional information. If you are *balance billed* in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.

At any time, you can request a printed 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 *physician's* office if you want to make an appointment. If you need help, call Member Services. We will help you make the appointment.

Member Identification Card

We will mail you a *member* identification card after we receive your completed enrollment materials, and you have paid your initial premium payment. This card is proof that you are enrolled in an Ambetter plan. You need to keep this card with you at all times. Please show this card every time you go for any service under this *contract*. The *member* identification card will show your name, *member* identification number, the phone numbers for Member Services, pharmacy, and 24/7 nurse advice line, and any *copayment amounts* required at the time of service. Any applicable *deductibles*, and any applicable out-of-pocket maximum limitations will also be accessible through the *member* identification card. If you do not get your *member* identification card within a few weeks after you enroll, please call Member Services. We will send you another card. A temporary *member* identification card can be downloaded from your secure consumer dashboard at member.AmbetterHealth.com.

Website

Our website can answer many of your frequently asked questions and has resources and features that make it easy to get quality care. Our website can be accessed at AmbetterHealth.com/en/OH. 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. *Deductible* and *copayment* accumulators.
8. Our formulary or *prescription drug* list.
9. Selecting a *PCP*.

Quality Improvement

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

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

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

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

Protection from Balance Billing

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

Ohio's House Bill 388 and the federal No Surprises Act establish patient protections including from *non-network providers'* surprise bills ("*balance billing*") for emergency care and other specified items or services. We will comply with these new state and federal requirements including how we process claims from certain *non-network providers*.

DEFINITIONS

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

Wherever used in this *contract*:

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

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

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

Adverse benefit determination means any of the following decisions by a health plan issuer:

1. To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:
    a. A determination that the health care service does not meet the health plan issuer's requirements for *medical necessity*, appropriateness, health care setting, level of care, or effectiveness, including *experimental* or *investigational* treatments;
    b. A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non-employer group, to participate in a plan or health insurance coverage;
    c. A determination that a health care service is not a *covered service*; and
    d. The imposition of an exclusion, including an exclusion for pre-existing conditions, source of *injury*, *network*, or any other limitation on benefits that would otherwise be covered.
2. Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-employer group;
3. To rescind coverage on a health benefit plan;
4. That *balance billing protections* apply to a service; or

5. Related to the amount of *cost sharing* a *member* owes when *balance billing protections* apply.

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

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

Note: If you receive services from a *non-network provider*, you may be responsible for the difference between the amount the provider charges for the service (*billed amount*) and the *allowed amount* that we pay. However, you will not be responsible for *balance billing* for non-network care that is subject to *balance billing protections* and otherwise covered under your *contract*. See *balance billing*, *balance billing protections*, and *non-network provider* definitions for additional information. If you are *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 Primary Care and *virtual 24/7 care* benefits, to *members*. All services provided through the *Ambetter-designated telehealth provider* shall be deemed independent from Ambetter to ensure that a *member's* care and treatment plan are rendered via a practicing *physician*, or other medical professional with appropriate licensure.

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

Appeal means a request by the *member* or their *authorized representative* for the insurer to reconsider, reverse, or otherwise modify an *adverse benefit determination*.

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

Applied behavior analysis (ABA) means the 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 a decision to approve the *medical necessity* or the appropriateness of care for a *member* by the *member's primary care physician (PCP)* or provider.

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

1. A person to whom you have given express, written consent to represent you in an internal *appeals* process or *external review* process of an *adverse benefit determination*;
2. A person *authorized* by law to provide substituted consent for you; or
3. A family member or a treating health care professional, but only when you are 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 *balance billed* contact Member Services immediately at the number listed on the back of your *member* identification card.

Balance billing protections mean 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.

Basic health care services mean the following services when *medically necessary*: *physician's* services; *inpatient hospital* services; *outpatient services*; emergency health services; urgent care services; diagnostic laboratory services and diagnostic and therapeutic radiologic services; diagnostic and treatment services, other than *prescription drug* services, for biologically based mental *illnesses*; preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care; and routine patient care for

patients enrolled in an *eligible cancer clinical trial* pursuant to *applicable law*. *Basic health care services* do not include *experimental* procedures. All *basic health care services* are covered under this *contract*.

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

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

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

Cardiac rehabilitation means to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning, and maintenance are not covered.

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

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

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

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

It does not include false labor, preeclampsia, edema, prolonged labor, provider 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*.

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

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

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

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

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

Covered person or ***member*** means you, your *spouse*, and each *eligible child*:

1. Named in the enrollment application; or
2. Whom we agree in writing to add as a *member*.

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

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

Custodial care means treatment designed to assist a *member* with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in

recovery from an *illness* or bodily *injury*. *Custodial care* includes (but is not limited to) the following:

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

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

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

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

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

Effective date means the date a *member* becomes covered under this *contract* for *illness* or *injury*.

Eligible cancer clinical trial means a cancer clinical trial that meets all of the following criteria:

1. A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
2. The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
3. The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
4. The trial does one of the following:
    a. Tests how to administer a health care service, item, or drug for the treatment of cancer;
    b. Tests responses to a health care service, item, or drug for the treatment of cancer;

c. Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer; or

d. Studies new uses of a health care service, item, or drug for the treatment of cancer.

5. The trial is approved by one of the following entities:

   a. The National Institutes of Health or one of its cooperative groups or centers under the United States Department of Health and Human Services;

   b. The United States Food and Drug Administration;

   c. The United States Department of Defense; or

   d. The United States Department of Veterans' Affairs.

6. A medical professional has determined the cancer clinical trial is appropriate for the *member*.

Eligible child means your or your *spouse's* child, if that child is less than 26 years of age. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child;
3. A foster child placed in your custody;
4. A stepchild;
5. A child placed with you for adoption; 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 Health Insurance Marketplace or us) if your child ceases to be an *eligible child*. You must reimburse us for any benefits that we provide or pay for a child at a time when the child did not qualify as an *eligible child*.

Eligible expense means a *covered service* 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 *applicable law*, the *eligible expense* is as follows:

    a. When a covered *emergency service* is received from a non-network facility, non-network ambulance (including the provider rendering services in such ambulance), or a *non-network provider* within Ohio, the *eligible expense* is the negotiated fee that has been agreed upon by us and the facility, ambulance, or provider. If there is no negotiated fee, the *eligible expense* will be determined based on the greatest of the following:

        i. The *contracted* amount we pay to *network providers* for the *covered service* in the same geographic area. If there is more than one *contracted* amount with *network providers* for the *covered service*, the amount is the median of these amounts;

        ii. 100 percent of the fee Medicare allows for the same or similar services provided in the same geographical area; or

        iii. The amount for the service calculated using the same method we generally use to determine payments for non-network health care services.

        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.

    b. When a covered *emergency service* is received from a *non-network provider* outside of Ohio, 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*. *Member cost share* will be calculated from the recognized amount based upon federal law. You should not be *balance billed* for the difference between the amount we pay and the provider's charges, but you may be subject to *cost sharing* obligations. 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.

    c. For all other *covered services* received from a *non-network provider* for which any needed *authorization* is received from us, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full (you will not be billed for the difference between the negotiated fee and the provider's charge). If there is no negotiated fee agreed to by the provider with us, the *eligible expense* is reimbursed 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 *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; or
3. Serious dysfunction of any bodily organ or part.

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

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 a 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 I, II, III or IV FDA clinical trials.

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

External review means a review by an external *third-party*, and *independent review organization* (*IRO*) which is binding, except to the extent that the health plan issuer has other remedies available under *applicable law*.

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 *contract*. The decision to apply *physician* specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by us. We may use the World Health Organization's International Classification of Diseases (ICD) and the American Psychiatric Association's Diagnostic and Statistical Manual for Mental Disorders (DSM) to inform *generally accepted standards of medical practice*.

Grievance means any *complaint* or dispute expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Health Insurance Marketplace health plan, or its providers, regardless of whether remedial action is requested.

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

Hearing aid means any wearable instrument or device designed or offered for the purpose of aiding or compensating for impaired human hearing, including all attachments, accessories, and parts thereof, except batteries and cords, that is dispensed by a licensed audiologist, a licensed *hearing aid* dealer or fitter, or an otolaryngologist.

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; and
4. Provides each patient with a planned program of observation and treatment by a *physician*, in accordance with existing standards of medical practice for the *injury* or *illness* requiring the *home health care*.

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

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

Hospital means an institution that:

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

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

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

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

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

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

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

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

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

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

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

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

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

Medical practitioner means, but is not limited to, a *physician*, nurse anesthetist, *physician's* assistant, physical therapist, or midwife. 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. The following are examples of providers that are NOT *medical practitioners*, by definition of the *contract*: acupuncturist, speech therapist, occupational therapist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, emergency medical technician, social worker, family counselor, marriage counselor, child counselor, naturopath, perfusionist, massage therapist, or sociologist.

Medically necessary or ***medical necessity*** means our decision as to whether any medical service, supply, item, 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. Demonstrate that the *member* is reasonably capable of improving in his/her functional ability;
5. Is not solely for the convenience of the provider or the *member*;
6. Is not *experimental* or *investigational*;
7. Is provided in the most cost-effective care facility or setting;
8. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; and
9. When specifically applied to a *hospital* confinement, it means that the diagnosis and treatment of your medical symptoms or conditions cannot be safely provided as an *outpatient*.

A charge incurred for treatment must be *medically necessary* or preventive care in order to be considered an *eligible expense*.

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

They do not include reusable or *durable medical equipment* and not able to be used by others. *Medically necessary medical supplies* do not include first aid supplies, cotton balls, rubbing alcohol, or like items routinely found in the home.

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

Mental health disorder means a condition – 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 version 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, Health Insurance Marketplace (“Marketplace”) plans, most individual plans sold outside of the Marketplace, Medicare, Medicaid, Children Health Insurance Program (CHIP), TRICARE, COBRA and plans sold through the Small Business Health Insurance Program (SHOP) Marketplace.

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 services* even if provided by a *non-network provider*.

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

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

Non-network provider means a *medical practitioner*, *provider facility*, or other provider who is NOT 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 Medical Service and Supply Benefits section of this *contract*;
2. Non-emergency health care services received at a *network* facility, as described in the Access to Care section of this *contract*;
3. Air ambulance services, and
4. Situations otherwise specifically described in this *contract*.

Notice and consent mean 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* occur only when each of the following conditions is met:

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

6. The *non-network provider* provides the *member* a copy of the signed written *notice and consent* through email or mail.

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

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

Orthotic device means a *medically necessary* device used to support, align, prevent or correct deformities, protect a body function, improve the function and moveable body part or assist with dysfunctional joints. Orthotics must be used 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 *contracts*, automobile no-fault or medical pay, homeowner insurance medical pay, premises medical pay, nonprofit health service plans, health maintenance organization *subscriber* contracts, self-insured group plans, prepayment plans, and Medicare when the *member* is enrolled in Medicare. *Other plan* will not include Medicaid.

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

Outpatient facility means any facility with a medical staff of *physicians* that operates pursuant to law for the purpose of performing medical or *surgical procedures*, and that does not provide accommodations for patients to stay overnight.

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

applicable law. A *physician* does **NOT** include someone who is related to a *covered person* by blood, marriage, or adoption or who is normally a *member* of the *covered person's* household.

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

Predetermination means a written request by the *member* to determine if a proposed treatment or service by the *member's PCP* or provider is covered under the *contract*. This process is voluntary, and the *predetermination* is dependent upon complete and accurate information submitted before the services are rendered. Payment is dependent upon the information submitted after the services are rendered.

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

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

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

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

Primary care physician or ***PCP*** means a *medical practitioner* 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 (OBGYN) 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 prior to receiving services.

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

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

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

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

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, including *surgery* after a mastectomy, in order to improve function or to improve the patient's appearance, to the extent possible.

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

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

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

Rehabilitation 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, which differs from the term in the General Provisions section, means a cancellation or discontinuance of coverage that has a retroactive effect. *Rescission* does not include a cancellation or discontinuance or coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

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

Residential treatment facility (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 disorders* and *mental health disorders*. *RTFs* do not provide acute care. They are generally used as a step-down from more intensive/acute care settings.

Note: The duration of stay covered under this *contract* for an *RTF* admission is based on *medical necessity*.

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 amount*, *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 Ohio 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 means a provider constituted, licensed, and operated as set forth in *applicable law*, which:

1. Mainly provides *inpatient* care and treatment for persons who are recovering from an *illness* or *injury*;
2. Provides care supervised by a *physician*;
3. Provides 24 hour per day nursing care supervised by a full-time registered nurse;
4. Is not a place primarily for care of the aged, custodial or domiciliary care, or treatment of alcohol or drug dependency; and
5. Is not a rest, educational, or custodial provider or similar place.

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

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

Spouse means the person to whom you are lawfully married.

Stabilize or ***stabilized*** 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 Medical Service and Supply Benefits section).

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

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

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

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

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.

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

Telehealth services means health care services provided through the use of information and communication technology by a health care professional, within the professional's scope of practice, who is located at a site other than the site where either of the following is located: (a) the patient receiving the services; or (b) another health care professional with whom the provider of the services is consulting regarding the patient. *Telehealth services* include but are not limited to synchronous interactions and asynchronous store and forward transfers. Store and forward transfers are processes, such as ones that use email to allow data to be stored until it can be sent if there is no connection available immediately.

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

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

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

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

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

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

Utilization review means a 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*, prospective review, second opinion, certification, concurrent review, *care management*, discharge planning, or retrospective review.

Virtual 24/7 care means a *telehealth service* 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 coverage under this *contract* on the latter of:

1. The date you became covered under this *contract*;
2. The date of marriage to add a *spouse*;
3. The date of an eligible newborn's birth; or
4. The first day of the premium period/first full calendar month after the date of becoming your dependent.

Effective Date for Initial Dependent Members

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

Adding 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. Each type of *covered service* incurred by the newborn child will be subject to the *cost sharing* amount listed in the *Schedule of Benefits*.

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

Adding an Adopted Child

As used in this provision, "placement" is the assumption and retention by you or your *spouse* for total or partial support of the child in anticipation of the adoption of the child.

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

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

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

have received both: (a) Notification of the addition of the child from the Health Insurance Marketplace 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.

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 member*.

ELIGIBILITY AND ENROLLMENT

For All Covered Persons

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

1. The date that a *member* is no longer within the grace period based on a failure to make timely payment. See the Grace Period provision for additional details;
2. The date that the primary *member* resides or moves permanently outside the *service area* of this *contract*;
3. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact;
4. The date we decline to renew this *contract*, as stated in the Discontinuance provision under the Termination section;
5. 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 *contract*, or any later date stated in your request will be effective the last day of the requested month but no further than 60 calendar days in advance; or
6. 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 Health Insurance Marketplace at Healthcare.gov or 1-800-318-2596. If you enrolled through us directly, contact Member Services by telephone.

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.

Proof of incapacity and dependence shall be furnished to us within 31 calendar days of the child's attainment of the limiting age. Upon request, but not more frequently than annually, we may require proof satisfactory to us of the continuance of such incapacity and dependency.

Out of Service Area Dependent Member Coverage

A *dependent member's* coverage will not cease should the *dependent member* live outside the *service area* if a court order requires the *member* to cover such *dependent member*.

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 Health Insurance Marketplace 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 on January 1st of the following year.

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

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

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

Special Enrollment

In general, a *qualified individual* has 60 calendar days to report certain life changes, known as "qualifying events" to the Health Insurance Marketplace. If a *qualified individual* loses Medicaid or CHIP coverage that is considered *minimum essential coverage*, they have up to 90 calendar days after the loss of *minimum essential coverage* to enroll in a Marketplace plan. *Qualified individuals* may be granted a special enrollment period where they may enroll in or change to a different Marketplace plan during the current plan year if they have a qualifying event. Qualifying events include:

1. A *qualified individual* or dependent loses *minimum essential coverage*, non-calendar year group or individual health insurance coverage, pregnancy-related coverage, access to health care services through coverage provided to a pregnant *member's* unborn child, or medically needed coverage;
2. A *qualified individual* gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order. In the case of marriage, at least one *spouse* must demonstrate having *minimum essential coverage* as described in 26 CFR 1.5000A-1(b) for one or more calendar days during the 60 calendar days preceding the date of marriage;

3. A *qualified individual* or dependent, who was not previously a citizen, national, or lawfully present individual gains such status; or who is no longer incarcerated or whose incarceration is pending the disposition of charges;
4. A *qualified individual's* enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or its instrumentalities as evaluated and are determined by the Health Insurance Marketplace;
5. A *member* or dependent adequately demonstrates to the Health Insurance Marketplace that the plan in which he or she is enrolled substantially violated a material provision of its *contract* in relation to the *member*;
6. A *qualified individual*, *member*, or dependent, adequately demonstrates to the Health Insurance Marketplace that a material error related to plan benefits, *service area*, or premium influenced the *qualified individual's* or *member*'s decision to purchase the *QHP*;
7. At the option of the Exchange, the *qualified individual*, or his or her dependent:
    a. Experiences a decrease in household income;
    b. Is newly determined eligible by the Exchange for advance payments of the premium tax credit; and
    c. Had *minimum essential coverage* as described in 26 CFR 1.5000A-1(b) for one or more days during the 60 calendar days preceding the date of the financial change.
8. A *member* or dependent enrolled in the same plan has a change in eligibility for *cost sharing reductions*;
9. A *qualified individual* or dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for *advance premium tax credits* based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-2(c)(3);
10. A *qualified individual*, *member*, or dependent gains access to new *QHPs* as a result of a permanent move, and had *minimum essential coverage* as described in 26 CFR 1.5000A–1(b) for one or more calendar days during the 60 calendar days preceding the date of the permanent move;
11. A *qualified individual* or dependent who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a plan or change from one plan to another one time per month;
12. A *qualified individual* or *member* demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by Health and Human Services (HHS), that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide;
13. A *qualified individual*, *member*, or dependent is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B–2, and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;

14. A *qualified individual* or dependent is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 calendar days after the qualifying event; or applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;
15. A *qualified individual* newly gains access to an employer sponsored Individual Coverage Health Reimbursement Arrangement (ICHRA) (as defined in 45 CFR 146.123(b)) or a Qualified Small Employer Health Reimbursement Arrangement (QSHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code);
16. At the option of the Health Insurance Marketplace, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a plan through the Health Insurance Marketplace following termination of enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315;
17. A *qualified individual* or dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions or government subsidies completely cease; or
18. A *qualified individual* who was previously ineligible for advance payments of the premium tax credit solely because of a household income below 100 percent of the federal poverty level and who, during the same timeframe, was ineligible for Medicaid because he or she was living in a non-Medicaid expansion state, who either experiences a change in household income or moves to a different state resulting in the *qualified individual* becoming newly eligible for advance payments of the premium tax credit.

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

If you are currently enrolled in an Ambetter from Buckeye Health Plan, please contact Member Services with any questions related to your health insurance coverage.

Coverage Effective Dates for Special Enrollment Periods

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

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

In the case of erroneous enrollment, *contract* violation, or exceptional circumstances, coverage is effective on an appropriate date based on the circumstances of the special enrollment

period, in accordance with guidelines issued by the Department of Health and Human Services. Such date must be either (i) the date of the event that triggered the special enrollment period or (ii) in accordance with the regular *effective dates*.

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

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

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

Prior Coverage

If a *member* is confined as an *inpatient* in a *hospital* on the *effective date* of this 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* services after the *effective date*, your Ambetter coverage will apply for *covered services* related to the *inpatient* services after your *effective date*. We require you to notify us within two calendar days of your *effective date* or as soon as reasonably possible so we can review and *authorize medically necessary* services. If services are at a non-network *hospital*, claims will be paid at the *allowed amount*, and you may be billed for any balance of costs above the *allowed amount*.

PREMIUMS

Premium Payment

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

Grace Period

When a *member* is receiving a premium subsidy:

After the first premium is paid, a grace period of three months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first 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 Health and Human Services (HHS) of the non-payment of premiums, the *member*, as well as providers, of the possibility of denied claims when the *member* is in the second and third month of the grace period. We will continue to collect *advance premium tax credits* on behalf of the *member* from the Department of the Treasury and will return the *advance premium tax credits* on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above.

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

Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a 60-calendar day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *contract* will stay in force; however, claims may pend for *covered services* rendered to the *member* and dependents 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 Health Insurance Marketplace of your new *residence* within 60 calendar days of the change. Your premium will be based on your new *residence* beginning on the first premium due date/first day of the next calendar month after the change. If your *residence* is misstated on your enrollment application, or you fail to notify us of a change of *residence*, we will apply the correct premium amount beginning on the first premium due date/first day of the first full calendar month you resided at that place of *residence*. If the change results in a lower premium, we will refund any excess premium back to the original method of payment and/or payor. If the change results in a higher premium, you will owe us the additional premium.

Misstatement of Tobacco or Nicotine Use

The answer to the t*obacco or nicotine* question on the enrollment application is material to our correct underwriting. If a *member's use of tobacco or nicotine* has been misstated on the *member's* enrollment application for coverage under this *contract*, we have the right to rerate the *contract* back to the original *effective date*.

Health Savings Account (HSA)

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

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

This Evidence of Coverage is administered by Ambetter from Buckeye Health Plan and underwritten by Buckeye Community Health Plan, Inc. Neither entity is an HSA trustee, HSA custodian or a designated administrator for HSAs. Buckeye Community Health Plan, Inc., its designee and its affiliates, including Ambetter from Buckeye Health Plan, 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

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

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

Authorization Requirements

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

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

1. Receives 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 telephone/e-fax/provider portal as follows:

1. At least five calendar days prior to an elective or scheduled 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 24 hours of receipt of the request. For all other urgent concurrent reviews, within 48 hours of receipt of the request.
2. For urgent pre-service reviews, within 48 hours of receipt of the request.
3. For non-urgent pre-service reviews, within ten calendar days of receipt of the request.
4. For post-service or retrospective reviews, within 30 calendar days of receipt of the request.

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

As used in this section, urgent care service means a medical care or other service for a condition where application of the timeframe for making routine or non-life-threatening care determinations is either of the following:

1. Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or
2. In the opinion of a *physician* with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

The determination whether a claim is an urgent care service claim will be determined by us; or, by a *physician* with knowledge of the *member's* medical condition.

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 Member Services before the service or supply is provided.

Electronic Procedure

Providers will have access to *authorization* forms through the provider portal that can be submitted to us and accepted for review through the same portal. We will provide an electronic receipt to the provider confirming receipt of the *authorization* request. If we request additional information, the provider must provide acknowledgement of the request for additional information to us.

If there is an operational difficulty, such as limited internet connectivity, or a financial hardship that prevents the provider from utilizing the electronic procedure, the provider may contact us to develop an appropriate process for receiving *authorization* requests.

Failure to Obtain Prior Authorization

Failure to comply with the *prior authorization* requirements will result in benefits being denied. If you disagree with our decision, you may *appeal* pursuant to the Appeals and Grievance Procedures section.

In cases where you receive *emergency services*, benefits will not be reduced for failure to comply with *prior authorization* requirements.

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

Authorization Does Not Guarantee Benefits

Our *authorization* does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *contract*. We will not retroactively deny *prior authorizations* as long as the *authorization* was obtained based on complete and accurate submission of all necessary information relative to an eligible *member* and the provider renders services in good faith and pursuant to the *authorization* and all of the terms and conditions of the provider's *contract* with us.

Requests for Predeterminations of Benefits

You may request a *predetermination* of coverage. 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, or is the responsibility of, someone else.

If you disagree with our decision, you may *appeal* pursuant to the Appeals and Grievance Procedures section.

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

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

Services from Non-Network Providers

Except for when *balance billing protections* apply to a *covered service* provided by a *non-network provider*, we do not normally cover services received from *non-network providers*. If a situation arises where a *covered service* cannot be obtained from a *network provider* located within a reasonable distance, we may provide 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 are responsible for ensuring that your *primary care physician* has requested *prior authorization* from us before you receive services from a *non-network provider*. Otherwise, you will be responsible for all charges incurred.

Appeal of Authorization Denial

Please refer to the Appeals and Grievance Procedures section of this *contract* for information on your right to *appeal* a denied *authorization*.

COST SHARING FEATURES

Cost Sharing Features

We will pay benefits for *covered services* as described in the *Schedule of Benefits* and the Medical Service and Supply Benefits section of this *contract*. All benefits we pay will be subject to all conditions, limitations, and *cost sharing* features of this *contract*. *Cost sharing* means that you participate or share in the cost of your health care services by paying *deductible amounts*, *copayments*, and *coinsurance amount* 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 amount* required for each type of service, as well as your *deductible*, is listed in your *Schedule of Benefits*.

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

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 are still responsible for their *deductible amount* until the family *deductible amount* is satisfied for the calendar year.

Copayments

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

Coinsurance

A *coinsurance amount* is your share of the cost of a service. *Members* may be required to pay a *coinsurance amount* in addition to any applicable *deductible amount(s)* for a *covered service*

or supply. *Coinsurance amounts* do not apply toward the *deductible* but do apply toward your *maximum out-of-pocket amount*.

Maximum Out-of-Pocket

You must pay a provider any applicable *copayments*, *coinsurance amount*, 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*.

The amount provided or payable will be subject to:

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

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

Non-Network Liability and Balance Billing

If you receive services from a *non-network provider*, you may have to pay more for services you receive. *Non-network providers* may be permitted to bill you for the difference between what we agreed to pay and the full *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 not change your selection more frequently than once a month. If you do not select a *network PCP* for each *member*, one will be assigned. You may obtain a list of *network PCPs* at our website and accessing the "Find a Doctor" function or by calling the telephone number shown on the front page of this *contract*.

You should get to know your *PCP* and establish a healthy relationship with them. Your *PCP* will:

1. Provide preventive care and screenings.
2. Conduct regular physical examinations as needed.
3. Conduct regular immunizations as needed.
4. Deliver timely service.
5. Work with other doctors when you receive care somewhere else.
6. Coordinate specialty care with *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 *PCP* for mental or *behavioral health* services, obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist.

Note: The *cost sharing* for covered physical therapy, occupational therapy, and *chiropractic care* will be no greater than the cost for an office visit to a *PCP* or a primary care osteopath *physician*.

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 1-877-687-1189 (TTY 1-877-941-9236). A licensed nurse is always available and ready to answer your health questions. If you are experiencing an *emergency condition*, call 911 or for a *behavioral health emergency condition*, call 988 or go to the nearest emergency room.

Changing Your Primary Care Physician (PCP)

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

Network Availability

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

Service Area

Ambetter from Buckeye Health Plan operates in a limited *service area*. If the *subscriber* moves from one county to another within the *service area*, the monthly premiums may be increased or changed. If the *subscriber* moves from one county in the *service area* to another that is not in the *service area*, you will no longer be eligible for coverage under this *contract* and will be eligible for special enrollment into another *qualified health plan*.

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 *contract*.

Emergency Services

If you are experiencing an *emergency condition*, call 9-1-1 or for a *behavioral health emergency condition*, call 988 or go to the nearest *hospital*. *Emergency services* do not require *prior authorization*. If those services provided are utilized at a non-network *hospital*, and a *member* presents with an emergency medical condition under one of the following circumstances, emergency care will be covered under 2(a) of the *eligible expense* definition:

1. Due to circumstances beyond the *member's* control, the *member* was unable to utilize a *network hospital's* emergency department without serious threat to life or health;
2. A prudent layperson with an average knowledge of health and medicine would have reasonably believed that, under the circumstances, the time required to travel to a *network hospital's* emergency department could result in one or more of the adverse health consequence;
3. A person *authorized* by us refers the *member* to an emergency department and does not specify a *network hospital's* emergency department;
4. An ambulance takes the *member* to a non-network *hospital* other than at the direction of the *member*;
5. The *member* is unconscious;
6. A natural disaster precluded the use of a *network hospital's* emergency department; or
7. The status of a *hospital* changed from *network* to non-network *hospital* with respect to *emergency services* during a *contract* year and no good faith effort was made by us to inform *members* of this change.

If you are experiencing an *emergency condition*, call 9-1-1 or for a *behavioral health emergency condition*, call 988 or go to the nearest *hospital*. *Emergency services* do not require *prior authorization*. If *emergency services* are received at a non-network facility or by a *non-network provider*, you should not be *balance billed*. If you are, please contact Member Services immediately at the number listed on the back of your *member* identification card. The applicable *deductible amount(s)*, *coinsurance amounts*, and *copayment amounts* are shown on your *Schedule of Benefits*.

Non-Emergency Services

If you are traveling outside of the Ohio *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 *network providers* outside of Ohio 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 a *network* 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 the nearest emergency room. Be sure to call us and report your emergency within one business day or as soon as reasonably possible. You do not need *prior authorization* for emergency care services.

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*. We will provide access to *third-party* services at preferred or discounted rate. The preferred or discounted rates to these services may be communicated to all *members* by email, mail or phone promotions. The preferred partnerships are optional benefits to all *members*.

Continuity of Care

Under the federal No Surprises Act, if a *member* is a *continuing care patient* with respect to a *network provider* and the contractual relationship with the provider is terminated – such that the provider is no longer in *network* – or 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 the *member* in a timely manner of the termination and of their right to elect continued transitional care from the provider;
2. Provide the *member* with an opportunity to notify us of the *member's* need for transitional care; and
3. Permit the *member* to elect to continue receiving benefits for the course of treatment relating to their status as a *continuing care patient* during the period beginning on the date the notice described in (1) is provided and ending on the earlier of
    a. 90 calendar days after the notice described in (1) is provided; or
    b. The date on which the *member* is no longer a *continuing care patient* with respect to the provider.

MEDICAL SERVICE AND SUPPLY BENEFITS

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

Essential health benefits are defined by federal 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 *contract* are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/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 *contract*.

Benefit Limitations

Limitations may also apply to some *covered services* that fall under more than one *covered service* category. Please review all limits carefully. We will not pay benefits for any of the services, treatments, items or supplies that exceed benefit limits. For example, pulmonary therapy has a limit of 20 *outpatient* visits per year, however, if it is rendered as part of a physical therapy (PT) visit, the visit would apply to the PT visit limit.

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*; or
7. Post-acute transition services and community reintegration services, including *outpatient* day treatment services, or any other post-acute treatment services are covered, if such services are necessary as a result of and related to an *acquired brain injury*.

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

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

Ambulance Services

Air Ambulance Service Benefits

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

1. In cases where the *member* is experiencing an *emergency condition*, to the nearest *hospital* that can provide services appropriate to treat the *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 is appropriate for the condition;
3. Transportation between *hospitals* or between a *hospital* and a more appropriate level of care when *authorized* by us;
4. When ordered by an employer, school, fire or public safety official and the *member* is not in a position to refuse; or
5. When a *member* is required by us to move from a *non-network provider* to a *network provider*.

Non-emergency air ambulance 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.

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 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; or
5. Ambulette.

Ambulance Services (Ground and Water)

Covered services will include ambulance services for ground and water transportation, 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 is appropriate for the condition;
3. Transportation between *hospitals* or between a *hospital* and a more appropriate level of care when *authorized* by us;
4. When ordered by an employer, school, fire or public safety official and the *member* is not in a position to refuse; or
5. When a *member* is required by us to move from a *non-network provider* to a *network provider*.

Prior authorization is not required for emergency ambulance transportation.

Note: Non-emergency ambulance transportation requires *prior authorization*. You should not be *balance billed* for covered ground or water ambulance services.

Exclusions:

No benefits will be paid for:

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

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 (ABA)* services. These services are subject to *prior authorization* to determine *medical necessity*. If multiple services are provided on the same day by different providers, a separate *copayment* and/or *coinsurance amount* will apply to each provider.

Breast Cancer Screenings

Covered services under this benefit are provided for two screening mammography views per breast to detect breast cancer in *members*. A screening mammography means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in an asymptomatic *member* and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. Coverage also includes the professional interpretation of film and digital breast tomosynthesis.

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

Note: If you are enrolled in a high *deductible* health plan (HDHP) that is HSA-eligible, the calendar year *deductible* will apply to breast cancer screenings that exceed the ACA's preventive care requirements.

Care Management Programs

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

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

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

Chiropractic Services

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

Clinical Trial Coverage

For purposes of this section a *qualified individual* means:

1. An individual eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; or
2. Either:
    a. The referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described below; or
    b. The participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described below.

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 is also included for *eligible cancer clinical trials*.

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;
    c. Items and services provided by the research sponsors free of charge for any *member* in the trial; and
    d. Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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 provision shall not apply to *members* who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

Covered 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.

If one or more participating providers is participating in a clinical trial, nothing prevents us from requiring that a *qualified individual* participate in the trial through such a participating provider if accepted in the trial.

If an approved clinical trial is conducted outside the state, a *qualified individual* shall not be prohibited from participating in the approved clinical trial. Participation in clinical trials is subject to *prior authorization* requirements as outlined in this *contract*.

Benefits for an *eligible cancer clinical trial* do not, however, include the following:

1. A health care service, item, or drug that is the subject of the cancer clinical trial or is provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
2. An *investigational* or *experimental* drug or device that has not been approved for market by the United States Food and Drug Administration;

3. Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
4. An item or drug provided by the cancer clinical trial sponsors free of charge for any patient; or
5. A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.

Diabetic Care

Benefits are available for *medically necessary* services and supplies used in the treatment of *members* 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 services;
4. Self-management equipment, and diabetic supplies such as urine and/or ketone strips, blood glucose monitors (including non-invasive monitors and monitors for the blind) for which a *medical practitioner* has written an order, 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 retinopathy examination screenings, as *medically necessary* per year.

Covered services also include all provider prescribed *medically necessary* equipment and supplies used for the management and treatment of diabetes. See “Durable Medical Equipment, Medical and Surgical Supplies, Orthotic Devices, and Prosthetics” and “Preventive Care Expense Benefits.” Screenings for gestational diabetes are covered under “Preventive Care Expense Benefits.”

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

Dialysis Services

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

Covered services include:

1. Services provided in an *outpatient* dialysis facility or when services are provided in the home;
2. Processing and administration of blood or blood components;
3. Dialysis services provided in a *hospital*; and
4. Dialysis treatment of an acute or chronic kidney ailment which may include the supportive use an artificial kidney machine.

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

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

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

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

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

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

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

Benefits for repairs and replacement do not include the following:

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

We may establish reasonable quantity limits for certain supplies, equipment, or appliance described below. *Durable medical equipment* and supplies are subject to *prior authorization* as outlined in this *contract*.

Disposable Medical Supplies

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

Durable Medical Equipment

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

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

1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for I.V. fluids and medicine.
5. Glucometer.
6. Tracheotomy tube.
7. Cardiac, neonatal, and sleep apnea monitors.
8. Augmentative communication devices are covered when we approve based on the *member's* condition.
9. 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.

10. One pair of eyeglasses or contact lenses per *member* following a covered cataract *surgery*.
11. The rental of one Continuous Passive Motion (CPM) machine per *member* following a covered joint *surgery*. Rental costs must not be more than the purchase price of a new item. *Prior authorization* requirements may apply.
12. The rental of a standard *hospital* bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.

Exclusions:

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

1. Air conditioners.
2. Ice bags/coldpack 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 Expense Benefits provision).
6. Med-injectors.

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

Orthotic Devices

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

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

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

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

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

Prosthetics

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

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

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

Exclusions:

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

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

Emergency Services

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

Note:

For unanticipated or *emergency services* received in a *network* facility from a *non-network provider*, from the time you present an emergency medical condition 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-reimbursed as determined by us and as required by *applicable law* may not *balance bill* you for the difference between the amount paid and the *non-network provider's* charge.

Services which we determine to meet the definition of *emergency services* will be covered, whether the care is rendered by a *network provider* or *non-network provider*. *Emergency services* rendered by a *non-network provider* will be covered as a *network* service and paid in accordance with the *eligible expense* definition. You will be responsible for any applicable *coinsurance amount*, *copayment* or *deductible*.

Benefits are provided for treatment of emergency medical conditions and emergency screening and stabilization services without *prior authorization* for conditions that reasonably appear to a prudent layperson to constitute an emergency medical condition based upon the patient's presenting symptoms and conditions. Benefits for emergency care include, but are not limited to, facility costs and *physician* services, and supplies and *prescription drugs* charged by that facility.

Care and treatment provided once you are *stabilized* is no longer considered emergency care. Continuation of care from a *non-network provider* beyond that needed to evaluate or *stabilize* your condition in an emergency will be covered as a non-network service unless we *authorize* the continuation of care, and it is *medically necessary*.

Family Planning and Contraception Services

Family planning and contraception benefits are covered under preventive care, without *cost sharing*, when provided by a *network provider*, and the care is legal under *applicable law*. These benefits include the following for adolescent and adult women in accordance with the

most recent guidelines supported by the Health Resources and Services Administration (HRSA):

1. The full range of contraceptives currently identified by the FDA, including:
    a. Sterilization *surgery* for women;
    b. Implantable rods;
    c. Copper intrauterine devices;
    d. Intrauterine devices with progestin (all durations and doses);
    e. Injectable contraceptives;
    f. Oral contraceptives (combined pill);
    g. Oral contraceptives (progestin only);
    h. Oral contraceptives (extended or continuous use);
    i. The contraceptive patch;
    j. Vaginal contraceptive rings;
    k. Diaphragms;
    l. Contraceptive sponges;
    m. Cervical caps;
    n. Condoms;
    o. Spermicides;
    p. Emergency contraception (levonorgestrel); and
    q. Emergency contraception (ulipristal acetate).
2. Coverage is also available for any additional contraceptives approved, granted, or cleared by the FDA (if the patient and the patient's attending provider have determined it to be medically appropriate).
3. Contraceptive care, such as: screening, education, provision of contraception, counseling and follow-up care (e.g., management, evaluation and changes, including the removal, continuation and discontinuation of contraceptives).
4. Instruction in fertility awareness-based methods, including lactation amenorrhea.
5. For all United States Food and Drug Administration (FDA)-approved contraception methods without *cost sharing* as required under the Affordable Care Act.

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 Expense Benefits

Coverage for *habilitation services* includes the following: physical, occupational and speech therapies, developmental services and *durable medical equipment* for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder, *autism spectrum disorder*, and mixed developmental disorder.

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

1. Evaluation and assessment services;
2. *Applied behavior analysis (ABA)* therapy;
3. Behavior training and behavior management;
4. Speech therapy;
5. Occupational therapy;
6. Physical therapy;
7. *Durable medical equipment* and devices;*
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 (ABA)* services. These services are subject to *prior authorization* to determine *medical necessity*. If multiple services are provided on the same day by different providers, a separate *copayment* and/or *coinsurance amount* will apply to each provider.

Habilitative developmental services examples include, but are not limited to, toileting, dressing, using fine motor skills, crawling, walking, categorization, expressing oneself (making wants and needs known), picture recognition, identifying letters, numbers, shapes, etc., appropriate play skills and coping mechanisms.

* *Durable medical equipment* and devices provided in conjunction with habilitative services are covered. Please see the *Durable Medical Equipment* coverage provision of this *contract*.

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 in a medical office. Coverage is provided for *medically necessary network* care provided at the *member's* home and includes the following:

1. Intermittent skilled nursing services (by an R.N. or L.P.N.).

2. Medical/social services.
3. Diagnostic services.
4. Nutritional guidance.
5. *Home health aide services*. The *member* must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the *home health care* provider. Other organizations may provide services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the *home health care* provider.
6. Therapy services (except for manipulation therapy which will not be covered when rendered in the home). Home care visit limits specified in the *Schedule of Benefits* for home care services apply when therapy services are rendered in the home.
7. Medical/surgical supplies.
8. *Durable medical equipment*.
9. *Prescription drugs* (only if provided and billed by a *home health care agency*).
10. Private duty nursing.

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

Home infusion therapy will be paid only if you obtain *prior authorization* from our home infusion therapy administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, *durable medical equipment*, and pharmaceutical services which are delivered and administered intravenously in the home. Home I.V. therapy includes but is not limited to injections (intra-muscular, subcutaneous, and continuous subcutaneous), Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain management, and chemotherapy.

Exclusions and Limitations:

No benefits will be payable for charges related to *respite care*, *custodial care*, or educational care, under the *home health care* service expense benefit. Non-covered services and supplies include, but are not limited to:

1. Food, housing, homemaker services, and home delivered meals.
2. Home or *outpatient* hemodialysis services (these are covered under Medical and Surgical Expense Benefits, Dialysis, and Durable Medical Equipment Services provisions).
3. *Physician* charges.
4. Helpful environmental materials (handrails, ramps, telephones, air conditioners, and similar services, appliances and devices).
5. Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a *contracting home health care* provider.

6. Services provided by a *member* of the patient's *immediate family*.
7. Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside.

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

Hospice Care Service Expense Benefits

This provision only applies to a *terminally ill member* receiving *medically necessary* care under a *hospice* care program or in a home setting. *Respite care* is covered on an *inpatient* or home basis to allow temporary relief to family members from the duties of caring for a *covered person*. Respite days that are applied toward the *deductible* are considered benefits provided and shall apply against any maximum benefit limit for these services. Benefits for *hospice inpatient*, home and *outpatient* care are subject to *prior authorization* as outlined in this *contract*. See the *Schedule of Benefits* for benefit levels or additional limits.

To be eligible for *hospice* benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending *physician*. *Covered services* will continue if the *member* lives longer than six months.

When approved by your *physician*, *covered services* and supplies include the following:

1. Skilled nursing services (by an R.N. or L.P.N.).
2. Diagnostic services.
3. Physical, speech, and inhalation therapies if part of a treatment plan.
4. Medical supplies, equipment, and appliances (benefits will not be covered for equipment when the *member* is in a facility that should provide such equipment).
5. Counseling services.
6. *Inpatient* confinement at a *hospice*.
7. *Prescription drugs* given by the *hospice*.
8. Home health aide.

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

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

1. Services provided by volunteers.
2. Housekeeping services.

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. The following are not *hospital* confinement under this *contract*: confinement in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility*, or *residential treatment facility*, halfway house, or transitional facility.
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 that are routinely provided by the *hospital* to *members* for use only while they are *inpatients*.
7. Emergency treatment of an *injury* or *illness*, even if confinement is not required. See your *Schedule of Benefits* for limitations.

Long Term Acute Care

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

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

Infertility

Covered services under this benefit are provided for *medically necessary* diagnostic and exploratory procedures to determine infertility including *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 amount*/*copayment*.

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

Lymphedema Benefit

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

Mastectomy Benefits

Covered services for a mastectomy include reconstruction of the breast on which the mastectomy has been performed; *surgery* and reconstruction of the other breast to produce a symmetrical appearance and prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema.

Maternity Coverage

Maternity coverage includes *inpatient* services, *outpatient services*, and *physician* home visits and office services. These services are used for normal or complicated *pregnancy*. Other maternity benefits include complications of *pregnancy* and any covered terminations of *pregnancies*.

Coverage for the *inpatient* postpartum stay for you and your newborn child in a *hospital* will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care. We do not require that a *physician* or other health care provider obtain *prior authorization* for deliveries. An *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require notification.

When a decision is made to discharge a *member* or newborn prior to the expiration of the applicable number of hours of *inpatient* care required to be covered, the coverage of follow-up care shall apply to all follow-up care that is provided within 72 hours after discharge.

Physician-directed or advanced practice registered nurse-directed follow-up care after delivery is also covered. Services covered as follow-up care include physical assessment of the *member* and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any *medically necessary* and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The coverage applies to services provided in a medical setting or through *home health care* visits. The coverage shall apply to a *home health care* visit only if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending *physician* or a certified nurse-midwife, if attending the *member* in collaboration with a *physician*, determines further *inpatient* postpartum care is not necessary for you or your newborn child, provided the following are met and the *member* concurs:

1. In the opinion of your attending *physician*, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
    a. The antepartum, intrapartum, and postpartum course of the *member* and infant;
    b. The gestational stage, birth weight, and clinical condition of the infant;
    c. The demonstrated ability of the *member* to care for the infant after discharge; and
    d. The availability of post discharge follow-up to verify the condition of the infant after discharge.

Covered services include at-home post-delivery care visits at your *residence* by a *physician* or nurse performed no later than 72 hours following you and your newborn child's discharge from the *hospital*. Coverage for this visit includes, but is not limited to:

1. Parent education;
2. Assistance and training in breast or bottle feeding; and
3. Performance of any maternal or neonatal tests routinely performed during the usual course of *inpatient* care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the *physician's* office.

Newborn Charges

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

Newborns' and Mothers' Health Protection Act Statement of Rights

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

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

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

Duty to Cooperate

We cover maternity care services or supplies related to a *member's pregnancy* when a *member* is acting as a *surrogate* and has entered into a surrogacy arrangement. For more information on excluded services, please see the General Non-Covered Services and Exclusions section. *Members* who are a *surrogate* at the time of enrollment or *members* who agree to a surrogacy arrangement during the plan year must, within 30 calendar days of enrollment or agreement to be a *surrogate*, send us written notice using the Notification of Surrogacy form AmbetterHealth.com/en/oh/resources/handbooks-forms/ to Ambetter from Buckeye Health Plan at:

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

In the event that a *member* fails to notify us as set forth herein, we reserve our right to recoup payments made on behalf of the *surrogate*.

Medical and Surgical Expense Benefits

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

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 *injury* or *illness* 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 chemotherapy (including oral chemotherapy), inhalation therapy, infusion therapy, and radiation therapy or treatment in a *hospital* or office setting.
5. For *durable medical equipment*, *prosthetic devices*, *orthotic devices* or other *medically necessary medical supplies* following a medical or *surgical procedure* such as crutches, orthopedic splints, braces or casts. Please see the Durable Medical Equipment, Medical and Surgical Supplies, Orthotic Devices and Prosthetics provision of this *contract*.
6. For hemodialysis, and the charges by a *hospital* or facility for the processing and administration of genetic testing, blood or blood components including cost of blood, blood plasma and blood plasma expanders, which is not replaced by or for you.
7. For the cost and administration of anesthesia, oxygen, drugs, medications and biologicals.
8. For *medically necessary* reconstructive or cosmetic *surgery* including, but not limited to:
    a. Reconstructive breast *surgery* charges as a result of a partial or total mastectomy for breast cancer. 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.
9. For *medically necessary* dental *surgery* due to:
    a. An accidental *injury* which results in damage to natural teeth. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
    b. *Surgery* to correct a functional defect which results from a congenital and/or acquired disease or anomaly.
    c. Cleft lip and cleft palate for an eligible *member*. *Covered services* include medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the treating *physician* or surgeon and such *physician* or surgeon certifies that such services are *medically necessary* and consequent to treatment of the cleft lip or cleft palate.
    d. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* charges for dental care, rendered by a dentist, provided to the following *members*:
        i. A *member* whose treating *medical practitioner* in consultation with the dentist, determines the *member* has a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective;

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*; or

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*.

10. For infertility counseling and planning services when provided by a *network provider* and testing to diagnose infertility.
11. For the treatment of breast cancer by dose-intensive chemotherapy bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy bone marrow transplants or stem cell transplants.
12. For routine patient care for *members* enrolled in an *eligible cancer clinical trial* that is deemed an *experimental* or *investigational* treatment if the services provided are otherwise considered *covered services* under this *contract*. See the Clinical Trial Coverage provision of this *contract*.
13. For the following types of *medically necessary* implants and tissue grafts:
    a. 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.
14. For X-rays, Magnetic Resonance Imaging (MRI), Computed Tomography (CT Scan), Positron emission tomography/Single Photon Emission Computed Tomography (PET/SPECT scanning) and other diagnostic services. See Radiology, Imaging and Other Diagnostic Testing provision of this *contract*.
15. For *medically necessary telehealth services*. *Telehealth services* not provided 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.
16. For *surgery* or services related to cochlear implants and bone-anchored *hearing aids*.

17. For *hearing aids* and all related services prescribed or recommend by an audiologist, otolaryngologist, *hearing aid* dealer, or fitter and considered medically appropriate according to professional standards established by the state speech and hearing professionals board. Coverage is only for *members* who are 21 years old and younger and who are deaf or hearing impaired as determined by a licensed audiologist, *physician*, or otolaryngologist. *Deductible amounts* and *cost sharing* provisions do not apply. Coverage is provided up to $2,500 and is limited to one *hearing aid* per hearing-impaired ear every 48 months with no cost shares. A *member* may choose a higher priced *hearing aid* and pay the difference. Related services that are necessary to assess, select, and appropriately adjust or fit *a hearing aid* to ensure optimal performance are not subject to the $2,500 limit.
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 Rehabilitation and Skilled Nursing Facility Expense Benefits and Habilitation Expense Benefits provisions of this *contract*.
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 *medically necessary* biofeedback services.
23. For abortions performed to save the life of the *member* or otherwise and performed in accordance with *applicable law*.
24. Cost for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation or transplant procedure.
25. For *medically necessary chiropractic care* or manipulative therapy treatment on an *outpatient* basis only.
26. 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.
27. For *medically necessary* allergy testing and treatment including allergy injections and serum.
28. When deemed *medically necessary* by your provider, nutritional counseling is a covered benefit.
29. For elective sterilization procedures (e.g., vasectomies) **Note:** No *cost share* applies, except on HSA-compatible plans.
30. For the testing of lead poisoning in pregnant women and other *members*.

31. For expenses or services related to immunizations and vaccinations for travel purposes.
32. For *medically necessary* services or treatment for:
    a. A medically verifiable disorder of sexual development; or
    b. *Behavioral health* treatment for gender dysphoria (e.g., psychotherapy).

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

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

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

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 *outpatient 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. *Covered services* may include oral examinations, x-rays, laboratory services, and prosthetic services. *Covered services* will not include damage resulting from chewing or parafunctional habit.

Medical Foods

We cover medical foods and formulas for:

1. *Outpatient* total parenteral nutritional therapy;
2. Nutritional counseling;
3. *Outpatient* elemental formulas for malabsorption;
4. Dietary formula when *medically necessary* for the treatment of Phenylketonuria (PKU) and inborn errors of metabolism; and
5. *Outpatient* elemental formulas for malabsorption.

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 one gram of protein per serving and are intended to be used under the direction of a *physician* for the dietary treatment of an inherited metabolic disease. Low protein food products do not include natural foods that are naturally low in protein.

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

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

Excluded are any other non-medical dietary formulas, oral nutritional supplements, special diets, prepared foods or meals, baby formula or food and formula for access problems.

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 because of any workers' compensation law or required by any governmental agency.
7. Orthoptics, vision training, or subnormal vision aids.
8. Non-network care, except when *prior authorized*.
9. Any vision services, treatment or material not specifically listed as a *covered service*.

Mental Health and Substance Use Disorder Benefits

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

Covered services will be provided on an *inpatient* and *outpatient* basis and include *mental health disorders* and *substance use disorder* diagnosis or conditions. If you need mental health and/or *substance use disorder* treatment, you may choose any provider participating in our mental health *network* and do not need a referral from your *PCP* in order to initiate treatment.

Deductible amounts, *copayment* or *coinsurance amounts* and treatment limits for covered *behavior 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 *contract,* are included on a non-discriminatory basis for all *members*. Treatment limitations applicable to *mental health disorders* and *substance use disorder* benefits will not be applied more stringently than those placed on coverage for medical and surgical benefits.

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

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

Inpatient

1. *Inpatient* psychiatric hospitalization;
2. *Inpatient* detoxification treatment;
3. Crisis stabilization;
4. *Inpatient rehabilitation*;
5. *Residential treatment facility* for *mental health disorders* 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 disorders* and *substance use disorders*;
6. Individual, family, and group therapy for *mental health disorders* and *substance use disorders*;
7. Medication assisted treatment – combines *behavioral health* therapy and medication to treat *substance use disorders*;
8. Medication management services;

9. Psychological and neuropsychological testing and assessment;
10. *Applied behavior analysis (ABA)*;
11. *Telehealth services*, provided on the same basis and to the same extent (including *cost share* amounts) for the provision of in-person health care services (includes individual/family therapy; medication monitoring; assessment and evaluation);
12. Electroconvulsive Therapy (ECT); and
13. *Transcranial Magnetic Stimulation (TMS)*.

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

1. Office visits include benefits such as individual therapy, group therapy, routine evaluation and management, medication monitoring/management, nutritional counseling, urgent care, and *telehealth services*.
2. Other *outpatient services* include benefits such as psychological testing, neuropsychological testing, electroconvulsive therapy, *transcranial magnetic stimulation*, *applied behavior analysis (ABA)*, medication assisted treatment, *outpatient* detoxification, intensive *outpatient* programs, partial hospitalization/day treatment (eight hours), partial hospitalization/half day treatment (four hours), laboratory procedures, and *habilitation*/*rehabilitation services* (physical therapy, speech therapy, and occupational therapy).

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

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

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

Opioid Treatment

Care Management Services for Opioid Use Disorder

All *members* are eligible for free, comprehensive *care management* services to help manage and coordinate care for their opioid use disorders. Our *care management* team has specialty trained *behavioral health* clinicians that work with *members* and providers to identify needs and barriers to secure resources and improve access to care. *Members* can contact Member

Services to enroll. Our specialty team may also proactively outreach *members* following *inpatient* admissions or emergency room visits related to their opioid use disorder.

We can help you:

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

Opioid Educational Tools

Our website has information and tools to assist you with locating providers and education related to opioid use disorder. The educational content provides an overview of the various types of treatment available. Our “Find a Doctor” page assists *members* with locating opioid treatment specialty providers in your preferred area.

No Prior Authorization Process for Opioid Use Disorder Treatment

Outpatient services for monitoring drug therapy, also known as Medication Assisted Treatment (MAT), does not require *prior authorization*. Treatment with drugs such as buprenorphine or methadone is an example of this type of benefit. In addition, medication management services utilized for opioid treatment, such as psychiatric evaluations and medication follow-up appointments do not require *prior authorization*.

Pediatric Vision Benefits – Children under the age of 19

This plan complies with the pediatric vision benefit requirements as defined by 45 CFR §156.110(b)(3). Coverage for vision services is provided for children under the age of 19 through the end of the plan year in which they turn 19 years of age and includes:

1. Routine ophthalmological examination
    a. Refraction
    b. Eye evaluation including dilation
2. Standard frames
3. Prescription lenses
    a. Single
    b. Bifocal
    c. Trifocal
    d. Lenticular
4. Additional lens options (including coating and tints)
    a. Progressive lenses (standard or premium)
    b. Intermediate vision lenses
    c. Blended segment lenses

d. Hi-Index lenses
e. Plastic photosensitive lenses
f. Photochromic glass lenses
g. Glass-grey #3 prescription sunglass lenses
h. Fashion and gradient tinting
i. Ultraviolet protective coating
j. Polarized lenses
k. Scratch resistant coating
l. Anti-reflective coating (standard, premium or ultra)
m. Oversized lenses
n. Polycarbonate lenses

5. Contact lens allowance (includes contact lens fitting)
6. Low vision evaluation/aids

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

IMPORTANT: If you opt to receive vision care services or vision care materials that are not *covered services* under this *contract*, a participating vision care provider may charge you his or her normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not *covered services*, the vision care provider will provide you with an estimated cost for each service or material upon your request.

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.

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

Preventive (Tier 0) - No *copayment* for those drugs that are used for prevention and are mandated by the Affordable Care Act. Select oral contraceptives, vitamin D, folic acid for women of child-bearing age, over-the-counter (OTC) aspirin, and smoking cessation products may be covered under this tier. Certain age limits may apply.

Preferred Generic (Tier 1A) - Lowest *copayment* for select drugs that offer the greatest value compared to other drugs used to treat similar conditions. Select over-the-counter (OTC) drugs may be covered under this tier.

Generic (Tier 1B) - Low *copayment* for those drugs that offer great value compared to other drugs used to treat similar conditions. Select over-the-counter (OTC) drugs may be covered under this tier.

Preferred Brand (Tier 2) - Medium *copayment* covers brand name drugs that are generally more affordable or may be preferred compared to other drugs to treat the same conditions.

Non-Preferred Brand (Tier 3) - High *copayment* covers higher cost brand name and non-preferred generic drugs. This tier may also cover non-specialty drugs that are not on the *prescription drug* list, but approval has been granted for coverage.

Specialty (Tier 4) - The highest *copayment* is for “specialty” drugs used to treat complex, chronic conditions that may require special handling, storage or clinical management. *Prescription drugs* covered under the specialty tier require fulfillment at a pharmacy that participates in Ambetter's "specialty" or "hemophilia" *networks*. For additional information on which pharmacies are within our "specialty" or "hemophilia" *networks*, please consult Ambetter website's pharmacy information section.

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

1. A *prescription drug*.
2. Any drug that, under the *applicable law*, may be dispensed only upon the written prescription of a provider unless covered under this *contract* and is permitted to be dispensed by a pharmacist pursuant to *applicable law*.
3. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one standard reference compendium; or
    b. Recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
4. Prescribed, oral anticancer medication.

Such *covered 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 *contract*. The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her *physician*.

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

Formulary or Prescription Drug List

The formulary or *prescription drug* list is a guide to available generic, 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. Positive changes (e.g., adding drugs to the formulary, drugs moving to a lower payment tier) can occur periodically after review by the committee. Changes to the formulary that could have an adverse financial impact to you (e.g., drug exclusion, drug moving to a higher payment tier, or drugs requiring step therapy or *prior authorization*) occur only annually. In the event that a drug is removed from the formulary, you will be notified within 60 calendar days.

For the most current formulary or *prescription drug* list or for more information about our pharmacy program, visit AmbetterHealth.com/en/OH or call Member Services.

Non-Formulary and Tiered Formulary Contraceptives:

Under the Affordable Care Act, you have the right to obtain contraceptives that are not listed on the formulary (otherwise known as “non-formulary drugs”) and tiered contraceptives (those found on a formulary tier other than “Tier 0 – no *cost share*”) at no cost to you on your or your *medical practitioner’s* request. To exercise this right, please get in touch with your *medical practitioner*. Your *medical practitioner* can utilize the usual *prior authorization* request provision. See “Prescription Drug Exception Process” section for additional details.

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 plan formulary (otherwise known as “non-formulary drugs”). To exercise this right, please get in touch with your *medical practitioner*. You can utilize the usual *prior authorization* request process. See the “Cost Sharing Features” section for additional details or your *maximum out-of-pocket amount*.

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

If you decide to have your prescription filled at a *network* pharmacy, you can use the provider directory to find a pharmacy near you. You can access the provider directory at AmbetterHealth.com/en/OH 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 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/OH. You can also request to have a copy mailed directly to you.

Mail Order Pharmacy/Prescription Drug Delivery

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

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 calendar days' supply of medication. This provision operates in addition to any applicable medication quantity limit or refill guidelines.

Split-Fill Dispensing Program

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

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 *appeals* rights.

Prescription Drug Exception Process

1. Standard exception request

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

2. 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 request be granted, we will provide coverage of the non-formulary drug for the duration of the exigency.

3. 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 (IRO)*.

For a *prior authorization* related to a chronic condition, the *authorization* for an approved drug will be honored for the lesser of 12 months or the last day of the *covered person's* enrollment under the *contract*.

Non-Covered Services and Exclusions:

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

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance unless such treatment is listed on the formulary.
2. For weight loss *prescription drugs* unless otherwise listed on the formulary.
3. For immunization agents otherwise not required by the Affordable Care Act.

4. For medication that is to be taken by the *member*, in whole or in part, at the place where it is dispensed.
5. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
6. For a refill dispensed more than 12 months from the date of a *physician's* order.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are listed on the formulary.
9. For drugs labeled "Caution - limited by federal law to *investigational* use" or for *investigational* or *experimental* drugs.
10. For any drug that we identify as therapeutic duplication through the drug *utilization review* program.
11. For more than a 30 calendar-day supply when dispensed in any one prescription or refill, or for maintenance drugs, up to 90 calendar day supply when dispensed by mail order or a retail pharmacy.
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 travelling 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 medications used for cosmetic purposes.
15. For infertility drugs unless otherwise listed on the formulary.
16. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by *applicable laws* and regulations.
17. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventative treatment is related to *member's* vacation during out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
18. For drugs or dosage amounts determined by Ambetter's Pharmacy and Therapeutic 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 drug related to *surrogate pregnancy*.

21. Medication refills where a *member* has more than 15 calendar days' supply of medication on hand.
22. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
23. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status.
24. Human growth hormone for children born small for gestational age.
25. Compound drugs unless there is at least one ingredient that is an FDA approved drug.

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 amount*, or *copayment*). For current information regarding available preventive care benefits, please access the federal government's website at: 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 (including behavioral therapy and nicotine replacement therapy), 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. If preventive and diagnostic services are performed during the same visit, applicable *cost share* will be taken for the latter. For HSA-compatible plans, the *deductible* cannot be waived for benefits that exceed the federal ACA preventive care requirements.

As new preventive care recommendations and guidelines are issued (by the USPSTF, CDC or HRSA), those services will become covered preventive care benefits. According to the ACA,

coverage of new recommendations and guidelines become effective upon a plan's start or anniversary date that is one year after the date the recommendation or guideline is issued.

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

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

Notification

As required by section 2715(d)(4) of the Public Health Service Act, we will provide 60 calendar days advance notice to you before any material modification will become effective, including any changes to preventive benefits covered under this *contract*. You may access our website or call Member Services 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/OH.

Covered preventive services for adults include, but are not limited to:

1. Abdominal Aortic Aneurysm one-time screening for adults of specified ages who have ever smoked;
2. Alcohol misuse screening and counseling;
3. Aspirin use to prevent cardiovascular disease for adults of certain ages;
4. Blood pressure screening for all adults;
5. Cholesterol screening for adults of certain ages or at higher risk;
6. Colorectal cancer screening for adults over 45;
7. Depression screening for adults;
8. Type 2 diabetes screening for adults with high blood pressure;
9. Diet counseling for adults at higher risk for chronic disease;
10. Hepatitis B screening for adults at high risk, including adults from countries with two percent or more Hepatitis B prevalence, and U.S.-born adults not vaccinated as infants and with at least one parent born in a region with eight percent or more Hepatitis B prevalence;
11. Hepatitis C screening for adults at increased risk, and one time for everyone born 1945-1965;
12. HIV screening for all adults at higher risk;
13. Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
    a. Diphtheria;
    b. Hepatitis A;
    c. Hepatitis B;

d. Herpes Zoster;
e. Human Papillomavirus;
f. Influenza (Flu Shot);
g. Measles, Mumps, Rubella;
h. Meningococcal;
i. Pneumococcal;
j. Tetanus, Diphtheria, Pertussis; and
k. Varicella.

14. Lung cancer screening for adults 55-80 at high risk for lung cancer because the adult is a heavy smoker or has quit in the past 15 years;
15. Obesity screening and counseling for all adults;
16. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;
17. *Tobacco or nicotine use* screening for all adults and cessation interventions for *tobacco or nicotine* users; and
18. Syphilis screening for all adults at higher risk.

Covered Preventive Services for Women and Pregnant Women include, but are not limited to:

1. Anemia screening on a routine basis for pregnant *members*;
2. Urinary tract or other infection screening for pregnant *members*;
3. BRCA counseling about genetic testing for *members* at higher risk;
4. One cytologic screening per year or more often if recommended by a *physician*;
5. A baseline screening mammograph for adult *members*, once a year. Supplemental breast cancer screenings, as described in the Breast Cancer Screenings provision above;
6. Breast cancer chemoprevention counseling for *members* at higher risk;
7. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing *members*;
8. Cervical cancer screening for sexually active *members*;
9. Chlamydia infection screening for younger *members* and other *members* at higher risk;
10. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for *members* with reproductive capacity (not including abortifacient drugs), to the extent such services and supplies are legal under *applicable law*;
11. Domestic and interpersonal violence screening and counseling for all *members*;
12. Folic Acid supplements for *members* who may become pregnant;
13. Gestational diabetes screening for *members* 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;

14. Gonorrhea screening for all *members* at higher risk;
15. Hepatitis B screening for pregnant *members* at their first prenatal visit;
16. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active *members*;
17. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for *members* with normal cytology results who are 30 or older;
18. Coverage for *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis;
19. Rh Incompatibility screening for all pregnant *members* and follow-up testing for *members* at higher risk;
20. *Tobacco or nicotine use* screening and interventions for all *members*, and expanded counseling for pregnant tobacco users;
21. Sexually Transmitted Infections (STI) counseling for sexually active *members*;
22. Syphilis screening for all pregnant *members* or other *members* at increased risk; and
23. Well-*member* visits to obtain recommended preventive services.

Covered Preventive Services for Children include, but are not limited to:

1. Alcohol and drug use assessments for adolescents;
2. Autism screening for children at 18 and 24 months;
3. Behavioral assessments for children of all ages. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
4. Blood pressure screening for children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
5. Cervical Dysplasia screening for sexually active adolescents;
6. Congenital Hypothyroidism screening for newborns;
7. Depression screening for adolescents;
8. Developmental screening for children under age 3, and surveillance throughout childhood;
9. Dyslipidemia screening for children at higher risk of lipid disorders. Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
10. Fluoride chemoprevention supplements for children without fluoride in their water source;
11. Gonorrhea preventive medication for the eyes of all newborns;
12. Hearing screening for all newborns;
13. Height, weight, and Body Mass Index measurements for children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
14. Hematocrit or Hemoglobin screening for children;

15. Hemoglobinopathies or sickle cell screening for newborns;
16. Hepatitis B screening for adolescents at high risk, including adolescents from countries with two percent or more Hepatitis B prevalence, and U.S.-born adolescents not vaccinated as infants and with at least one parent born in a region with eight percent or more Hepatitis B prevalence: 11-17 years;
17. HIV screening for adolescents at higher risk;
18. Hypothyroidism screening for newborns;
19. Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
    a. Diphtheria, Tetanus, Pertussis;
    b. Haemophilus influenzae type b;
    c. Hepatitis A;
    d. Hepatitis B;
    e. Human Papillomavirus;
    f. Inactivated Poliovirus;
    g. Influenza (Flu Shot);
    h. Measles, Mumps, Rubella;
    i. Meningococcal;
    j. Pneumococcal;
    k. Rotavirus; and
    l. Varicella.
20. Iron supplements for children ages 6 to 12 months at risk for anemia;
21. Lead screening for children at risk of exposure;
22. Medical history for all children throughout development. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
23. Obesity screening and counseling;
24. Oral health risk assessment for young children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years;
25. Phenylketonuria (PKU) screening for this genetic disorder in newborns;
26. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
27. Tuberculin testing for children at higher risk of tuberculosis. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years; and
28. Vision screening for all children.

Prostate Specific Antigen Testing

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

Radiology, Imaging and Other Diagnostic Testing

Medically necessary radiology services, imaging and tests performed for diagnostic reasons are a *covered service* (e.g., X-ray, Magnetic Resonance Imaging (MRI), Computed Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT), mammogram, ultrasound). *Prior authorization* may be required, see your *Schedule of Benefits* for details.

Note: Depending on the service performed, two bills may be incurred – both subject to any applicable *cost sharing* – one for the technical component (the procedure itself) and another for the professional component (the reading/interpretation of the results by a *physician* or other qualified practitioner). The total benefit for a screening mammography shall not exceed 130 percent of the Medicare reimbursement rate in this state for screening mammography. If there is more than one Medicare reimbursement rate in this state for screening mammography or a component of a screening mammography, the reimbursement limit shall be 130 percent of the lowest Medicare reimbursement rate in this state.

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.

Rehabilitation and Skilled Nursing Facility Expense Benefits

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the *member's* ability to function as independently as possible, including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy, and services of a social worker or psychologist. The goal is to obtain practical improvement, or maintain the *member's* abilities, in a reasonable length of time in the appropriate *inpatient* setting.

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

1. *Covered services* available to a *member* while confined primarily to receive *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 *skilled nursing facility* for:
    a. Daily room and board and nursing services.
    b. Diagnostic services.

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-provider facility services are limited to charges incurred for the professional services of *rehabilitation medical practitioners*.
4. Coverage includes pulmonary *rehabilitation*.

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*.

Exclusions:

Non-covered services for physical medicine and *rehabilitation* include, but are not limited to:

1. Admission to a *hospital* mainly for physical therapy; or
2. Long term *rehabilitation* in an *inpatient* setting.

Limitations:

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

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* amount for the consultation. Any lab tests and/or diagnostic and therapeutic services are subject to the additional *cost sharing*.

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

Sleep Studies

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

Transplant Expense Benefits

Covered services for transplant service expenses:

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

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

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

If we determine that a *member* is an appropriate candidate for a *medically necessary* transplant, medical service expense benefits will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting of the organ from the donor.
3. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
4. Including *outpatient covered services* related to the transplant *surgery*, pre-transplant laboratory testing and treatment, such as high dose chemotherapy, peripheral stem cell collection, and other immunosuppressive drug therapy, etc. 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 be medically *stabilized* to prepare for a later transplant, whether or not the transplant occurs.
6. The transplant itself, including the acquisition cost for the organ or bone marrow when *authorized* through the *Center of Excellence* and services are performed at a *network* facility.

7. Post-transplant follow-up visits and treatments. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.
8. All costs incurred and medical expenses by the donor shall be paid under the transplant recipient policy. This excludes travel, lodging, food, and mileage.
9. Pre-transplant evaluation services including medical consultations, office visits, laboratory, and diagnostic testing.

Please refer to the Member Transplant Travel Reimbursement Policy for outlined details on reimbursement limitations at AmbetterHealth.com/en/oh/resources/handbooks-forms/.

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

Ancillary "*Center of Excellence*" Service Benefits:

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

1. We will pay for the following services when the *member* is required to travel more than 60 miles from the *residence* to the *Center of Excellence*:
2. We will pay a maximum of $10,000 per transplant service for the following services:
    a. Transportation for the *member*, any live donor, and the companion(s) to accompany to and from the *Center of Excellence*, in the United States.
    b. When a *member*, donor, and/or companion(s) is utilizing their personal transportation vehicle, a mileage log is required for reimbursement.
    c. Maximum reimbursement for mileage is limited to the total miles traveled by the transplant recipient and by the donor and their respective companion(s), to and from their respective homes to the transplant facility, plus miles traveled:
        i. Between the transplant facility and local lodging; and
        ii. Between a transit hub (e.g., airport, train station, bus station) and either the transplant facility or local lodging.
    d. Lodging at or near the *Center of Excellence* for any live donor and the companion(s) accompanying the *member* while the *member* is confined in the *Center of Excellence* in the United States. We will reimburse *members* for the proof of costs directly related for transportation, lodging and any of the 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.

Note: Please refer to the Member Resources page for travel reimbursement forms and information at AmbetterHealth.com/en/oh/resources/handbooks-forms/.

Non-Covered Services and Exclusions:

No benefits will be provided or paid under these Transplant Service 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 transplant.
7. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the FDA regulation, regardless of whether the trial is subject to FDA oversight.
8. The acquisition cost for the organ or bone marrow, when provided at an unauthorized facility or not obtained through the *Center of Excellence*.
9. For any transplant services and/or travel related expenses for *member* and donor, when performed outside of the United States.
10. The following ancillary items listed below, will not be subject to *member* reimbursement under this *contract*:
    a. Alcohol/tobacco.
    b. Car, trailer, or truck rental (unless pre-approved by Case Management).
    c. Vehicle maintenance for motorized and hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.).
    d. Parking (unless preapproved by the Case Management).
    e. Storage rental units.
    f. Temporary housing incurring rent/mortgage payments.
    g. Loss of wages due to time off from work required for transplant for recipient, donor, or companion(s).
    h. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
    i. Moving violation tickets or parking tickets.
    j. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.).
    k. Any services related to pet care, boarding, lodging, food, and/or travel expenses.
    l. Expenses for persons other than the transplant recipient, donor, or their respective companion(s).

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

n. Any expense not supported by a receipt.

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

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

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

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

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

t. All other items not described in the *contract* as *eligible expenses.*

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

v. Any tips, concierge, club level floors, and gratuities.

w. Salon, barber, and spa services.

x. Insurance premiums.

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

Urgent Care Service Benefits

Urgent care includes *medically necessary* services by *network providers* and services provided at a *network urgent care center*, including facility costs and supplies, or care for a condition that is not an emergency, but is an unforeseen medical *illness*, *injury*, or condition that requires immediate care when the *member's PCP* is unavailable or inaccessible. Urgent care is covered at *network hospitals*, *network urgent care centers*, or *network providers'* offices, but your zero *cost sharing* preventive care benefits may not be used at an *urgent care center*. Urgent care received at any *hospital* emergency department is not covered unless *authorized* in advance by us.

Members are encouraged to contact their *PCP* for an appointment before seeking care from another provider, but *network urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *PCP* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-877-687-1189. 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.

Urgent care is not covered for services received by a *non-network provider* or at a non-network facility.

WELLNESS PROGRAMS AND OTHER OFFERINGS

In connection with this *contract*, we may offer wellness programs and other services to *members* that serve to remove barriers to accessing health services and improve overall health outcomes. These programs and services are available when your coverage begins and continue as long as your coverage remains active. Participation in these programs and services is optional and available at no additional cost to *members*. The programs and services are available to you as part of this *contract* but are not insurance. We may make changes to the terms and conditions of the programs and services or discontinue them at any time. Program tools and service may vary within your market. To inquire about these programs and other offerings, and to learn about what programs are available in your area, please visit our website at AmbetterHealth.com/en/OH 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 *contract*, such as the “Ambetter Perks” program, which offers discounts on a wide range of activities, services, goods, financial tools, memberships, out-of-pocket prescription expenses, over-the-counter (OTC) health products, and health- and wellness-related services addressing *social determinants of health* and healthy lifestyle. *Members* are responsible for paying for the discounted goods or services and we do not endorse any vendor, goods or services associated with the program. *Members* may also have access to a zero-interest line of credit through the Ambetter Perks program for paying their *deductibles*, *copayments*, and *coinsurance amounts* on *covered services*, with several repayment options to fit their needs. The Ambetter Perks program is offered to all *members*. We are not involved in administering programs; you will communicate directly with any vendors if you choose to participate.

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

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

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*, except as expressly provided for under the *contract's* Termination section.
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*, except as specifically covered in the Medical Service and Supply Benefits section of this *contract*.
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* or otherwise not illegal under *applicable law*.
7. For expenses for television, telephone, or expenses for other persons.
8. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.

9. For telephone consultations between providers, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
10. For *dental service* expenses, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Medical Service Expense Benefits.
11. For *cosmetic treatment*, except for *medically necessary reconstructive surgery* that is incidental to or follows *surgery* or an *injury* or is performed to correct a birth defect.
12. For diagnosis or treatment of learning disabilities.
13. For diagnosis or treatment of nicotine addiction, except as expressly provided for under Preventive Care Expense Benefits provision.
14. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
15. For services while confined primarily to receive *rehabilitation*, *custodial care*, educational care, or nursing services (unless expressly provided for in this *contract*).
16. For vocational or recreational therapy, vocational *rehabilitation*, *outpatient* speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
17. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
18. For *hearing aids* or fittings related to these devices for *members* over the age of 21, except as expressly provided in this *contract*.
19. 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.
20. For treatment received outside the United States, except for a medical emergency while traveling for up to a maximum of 90 consecutive days.
21. For an *injury*, disease, defect, or ailment arising out of and 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 state or federal law. If workers' compensation insurance is not available to you, then this exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any *third-party*. 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.

22. For surrogacy arrangements. Health care services, including supplies and medication to a non-member *surrogate* and any child born as a result except where the child is the adoptive child of a *member* possessing an active *contract* with us and/or the child possesses an active *contract* with us at the time of birth. This exclusion applies to all health care services, supplies and medication to the non-member *surrogate* including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the *surrogate* following childbirth);
    d. Mental health services related to the surrogacy arrangement;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a surrogacy arrangement;
    g. Use of frozen gamete or embryos to achieve future conception in a surrogacy arrangement;
    h. Preimplantation genetic diagnoses relating to a surrogacy arrangement; including but not limited to labs, imaging, and diagnostics;
    i. Any complications of the *surrogate* resulting from the *pregnancy*;
    j. Any other health care services, supplies and medication relating to a surrogacy arrangement;
    k. Pre-counseling, advice on procreation, or consultations related to gestational carriers or donor services;
    l. Any corrective *surgeries* or laparoscopic procedures for the sole purpose of a surrogacy arrangement; or
    m. For any other medical or healthcare services related to the *pregnancy* or preparations of becoming a *surrogate* or donor will not constitute as a covered benefit.

    Any and all other health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a surrogacy arrangement are also excluded, except when the child possesses an active *contract* with us at the time of birth.
23. For fetal reduction *surgery*.
24. Except as specifically identified as a *covered service* under the *contract*, for services or expenses for alternative treatments, including acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
25. For court ordered testing or care unless *medically necessary*.
26. For domiciliary care provided in a residential institution, treatment center, halfway house, or school because a *member's* own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

27. For services or care provided or billed by a school or *custodial care* center for the developmentally disabled.
28. For bariatric *surgery*.
29. For diagnostic testing, laboratory procedures, screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment. This exclusion does not apply to preventive services.
30. For human growth hormone for children born small for gestational age.
31. For surgical treatment of Gynecomastia.
32. For any medicinal and recreational use of cannabis or marijuana.
33. For all health care services obtained at an *urgent care center* that is a *non-network provider*.
34. 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.
35. For expenses, services, and treatments from a naturopathic specialist for treatment of prevention, self-healing and use of natural therapies.
36. For dry needling.
37. 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.
38. For the following miscellaneous items: artificial insemination (except where required by federal or state law); non-medically necessary or non-preventive care, 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; processing fees; *rehabilitation* services for the enhancement of job, athletic, or recreational performance; routine or elective care outside the *service area*; treatment of spider veins; transportation expenses, or complications resulting from non-covered services, unless specifically described in this *contract*.
39. For doula services.
40. For expenses or services related to immunizations and vaccinations for occupational purposes.

41. For any specified sex-trait modification procedures, in accordance with federal regulations in 45 CFR § 156.115(d), which include any pharmaceutical or surgical intervention that is provided for the purpose of attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex either by intentionally:
    a. Disrupting or suppressing the normal development of natural biological functions, including primary or secondary sex-based traits; or
    b. Altering an individual's physical appearance or body, including amputating, minimizing or destroying primary or secondary sex-based traits such as the sexual and reproductive organs.

TERMINATION

Termination of Contract

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*;
2. The date you are no longer eligible for coverage – the last day of coverage is the last day of the month following the month in which the notice is sent by us unless you request an earlier termination *effective date*; or
3. For a covered *eligible child* reaching the limiting age of 26, coverage under this *contract* will terminate at 11:59 p.m. on the last day of the year in which the *eligible child* turns 26.

Refund Upon Cancellation

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

Discontinuance

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

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

Notification Requirements

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

RIGHT OF REIMBURSEMENT

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

If a *member's illness* or *injury* is caused by the acts or omissions of a *third-party*, we will not cover a *loss* to the extent that it has already been paid for as part of a settlement or judgment by any *third-party*.

However, if payment by or for the *third-party* has not been made by the time we receive acceptable *proof of loss*, we will pay regular *contract* benefits, as outlined in our Claims section and pursuant to Ohio Prompt Payment Law, for the *member's loss*. By accepting benefits under this *contract*, the *member* specifically acknowledges our rights of subrogation and reimbursement. The rights of subrogation and reimbursement attach when we have provided health care benefits for expenses incurred due to *third-party injuries*.

By accepting benefits under this plan, the *member* specifically acknowledges Ambetter's right of subrogation. When this plan provides health care benefits for expenses incurred due to *third-party injuries*, Ambetter shall be subrogated to the *member's* rights of recovery against any party to the extent of the full cost of all benefits provided by this plan. Ambetter may proceed against any party with or without the *member's* consent. The amount that we may recover may be diminished as described in Ohio Revised Code section 2323.44.

By accepting benefits under this plan, the *member* also specifically acknowledges Ambetter's right of reimbursement. If the *member's* or the *member's* representative receives any payment as a result of a *third-party injury*, we will have the right to be reimbursed to the extent permitted by Ohio law, for benefits we provided or paid for the *illness* or *injury*. The *member* (or the guardian, legal representatives, estate, or heirs of the *member*) shall promptly reimburse us from the settlement, judgment, or any payment received from any *third-party*. These sources include, but are 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 *injuries* caused by a *third-party*.

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

1. To fully cooperate with us in order to obtain information about the *loss* and its cause.
2. To immediately inform us in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.

3. To include the amount of benefits paid by us on behalf of a *member* in any claim made against any *third-party*.
4. That we:
    a. Will have a lien on all money received by a *member* in connection with the *loss* to the extent permitted by Ohio law.
    b. May give notice of that lien to any *third-party* or *third-party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect our rights.

Furthermore, as a condition of our payment, we may require the *member* or the *member's* guardian (if the *member* is a minor or legally incompetent) to execute a written reimbursement agreement. However, the terms of this provision remain in effect regardless of whether or not an agreement is actually signed.

We will not pay attorney fees or costs associated with the *member's* claim or lawsuit unless we previously agreed in writing to do so.

If a dispute arises as to the amount a *member* must reimburse us, the *member* (or the guardian, legal representatives, estate, or heirs of the *member*) agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by us until the dispute is resolved. Additionally, either party may file an action pursuant to Ohio law to resolve any issue related to the distribution of any money recovered from the *third-party*.

However, if less than the full value of the *loss* is recovered because of comparative negligence, diminishment due to a party’s liability pursuant to Ohio law, or by reason of the collectability of the full value of the claim for *injury*, death, or *loss* to person resulting from limited liability insurance or any other cause, our reimbursement amount shall decrease in the same proportion as the *member’s* interest.

COORDINATION OF BENEFITS

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

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

Definitions

For the purpose of this section, the following definitions shall apply:

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

    a. Plan includes group and non-group insurance *contracts*; health insuring corporation (HIC) *contracts*; coverage under group or non-group closed panel plans (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.

    b. Plan does not include *hospital* indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident-type coverage; non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

    Each *contract* for coverage under a and b above is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

2. This plan means, in a COB provision the part of the *contract* providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of *other plans*. Any other part of the *contract* providing health care benefits is separate from this plan. A *contract* may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

3. The order of benefit determination rules determines whether this plan is a "primary plan" or "secondary plan" when you have health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any *other plan* without considering any *other plan's* benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100 percent of the total allowable expense.

4. Allowable expense is a health care expense, including *deductibles*, *coinsurance amounts*, and *copayments*, that is covered at least in part by any plan covering you. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering you is not an allowable expense. In addition, any expense that a provider by law or in accordance with a *contractual* agreement is prohibited from charging you is not an allowable expense. The following are examples of expenses that are not allowable expenses:
    a. The difference between the cost of a semi-private *hospital* room and a private *hospital* room is not an allowable expense, unless one of the plans provides coverage for private *hospital* room expenses.
    b. If you are covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
    c. If you are covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
    d. If you are covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has *contracted* with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's *contract* permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.
    e. The amount of any benefit reduction by the primary plan because you have failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
5. Closed panel plan is a plan that provides health care benefits to you primarily in the form of services through a panel of providers that have *contracted* with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
6. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When you are 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 according to its terms of coverage and without regard to the benefits under any *other plan*.
2. (1) Except as provided in paragraph (2), a plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.

   (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the *contract* holder. Examples of these types of situations are major medical coverages that are superimposed over base plan *hospital* and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide non-network benefits.
3. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that *other plan*.
4. Each plan determines its order of benefits using the first of the following rules that apply:
   a. **Non-Dependent or Dependent.**

      The plan that covers you other than as a dependent, (for example as an employee, *member*, policyholder, *subscriber*, or retiree) is the primary plan and the plan that covers you as a dependent is the secondary plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering you as a dependent, and primary to the plan covering you as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering you 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 child is covered by more than one plan the order of benefits is determined as follows:

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

         a) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan;

         b) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan;

         c) However, if one *spouse's* plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

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

a) If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;

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

c) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of paragraph a. above determine the order of benefits; or

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

1) The plan covering the custodial parent, first;

2) The plan covering the *spouse* of the custodial parent, second;

3) The plan covering the noncustodial parent, third; and then

4) The plan covering the *spouse* of the noncustodial parent, last.

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

c. **Active Employee or Retired or Laid-off Employee**

The plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering you as a retired or laid-off employee is the secondary plan. The same would hold true if you are a dependent of an active employee and you are a dependent of a retired or laid-off employee. If the *other plan* does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the non-dependent or dependent provision above can determine the order of benefits.

d. **COBRA or State Continuation Coverage**

If you have coverage provided under COBRA or under a right of continuation provided by state or other federal law and you are also covered under another plan, the plan covering you as an employee, *member*, *subscriber*, or retiree or covering you as a dependent of an employee, *member*, *subscriber*, or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the *other plan* does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the non-dependent or dependent provision above can determine the order of benefits.

e. **Longer or Shorter Length of Coverage**

The plan that covered you as an employee, *member*, policyholder, *subscriber*, or retiree longer is the primary plan, and the plan that covered you for the shorter period of time is the secondary plan. If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

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

Effect on the Benefits of This Plan

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

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and *other plans*. 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 you. We need not tell, or get the consent of, any person to do this. To claim benefits under this plan, you must give us any facts we need to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, we 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. We 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 us is more than it 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 you. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting Member Services by telephone or AmbetterHealth.com/en/OH. You should also refer to the *complaint* and *appeals* procedures. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer *complaint*. Call 1-800-686-1526 or visit the Department's website at insurance.ohio.gov.

CLAIMS

Notice of Claim

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

Proof of Loss

We must receive written *proof of loss* within 90 calendar days of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than one year 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. If we do accept the *proof of loss* after a year, we will then process the *proof of loss* within 90 calendar days.

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 itemized bill or itemized statement 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/OH. Send all the documentation to us at the following address:

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

Cooperation Provision

Each *member*, or other person acting on his or her behalf, must cooperate fully to assist us in determining our rights and obligations under the *contract*.

Time for Payment of Claims

Benefits will be paid within 30 calendar days after receipt of *proof of loss*. Should we determine that additional supporting documentation is required to establish responsibility of payment, we shall pay benefits within 45 calendar days after receipt of *proof of loss*. If we do not pay within such period, we shall pay interest at the rate of 18 percent per annum from the 31st calendar day after receipt of such *proof of loss* to the date of late payment.

Payment of Claims

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

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

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

Claims Incurred for Emergency Services While Traveling Outside the United States

Medical *emergency services* are covered for up to 90 consecutive days while traveling outside of 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 also include clinical documentation (medical records) that supports all *emergency services* received. Claims and medical records must be submitted in English or with an English translation, at the *member's* expense, to show proper *proof of loss* and evidence of any payment(s) to the provider. Proof of departure from and arrival to the United States must be submitted with the claim. These documents must be submitted with the Member Reimbursement Medical Claim Form, along with all requested documents as detailed on the claim form. All forms and *member* resources are available at AmbetterHealth.com/en/OH.

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 *authorization*, shall not confer upon such *hospital* or person, any right or privilege granted to you under the *contract* except for the right to receive benefits, if any, that we have determined to be due and payable.

Custodial Parent

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

Upon request by the custodial parent, we will:

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

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

Physical Examination

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

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/oh/privacy-practices/ or call Member Services.

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

Language Assistance

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

Legal Actions

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

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

Non-Assignment

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

No Third-Party Beneficiaries

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

APPEALS AND GRIEVANCE PROCEDURES

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

Call Member Services

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

Appeals Procedures

An *appeal* is a request by the *member* or their *authorized representative* for the insurer to reconsider, reverse, or otherwise modify an *adverse benefit determination*. You can designate a representative – such as a family member, friend, *physician*, or attorney - to *appeal* these decisions on your behalf.

Filing an Appeal

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

You can file an *appeal* by filling out the form included with the denial notice or sending a letter to:

Ambetter from Buckeye Health Plan
Attn: Appeals Department
4349 Easton Way, Suite 120
Columbus, OH 43219
Fax: 1-866-719-5404

You can also file an *appeal* via phone by contacting Member Services by telephone.

Processing Your Appeal

After you file your *appeal*, we will notify you of all the information that is needed to process the *appeal* within three business days of receipt of the *appeal*. You will be informed that you can present any information that you wish for us to consider as part of the *appeal*. We will investigate the *appeal* to decide if more information is needed from you or your provider.

A reviewer of the same or similar specialty will review the request and make a determination. This reviewer will not be the *physician* involved in the original decision and who is not the subordinate of that *physician*.

We will make the decision within 30 calendar days for pre-service *appeals* and 30 calendar days for post-service *appeals*, of receipt of your *appeal*.

We will notify you or your *authorized representative* in writing within two business days of the decision, not to exceed the total resolution timeframe. The notice will include an explanation of our decision, a reference to the criteria on which the decision was based, a list of the title and qualifications of each person participating in the review, and a description of your further *appeal* rights. Your further *appeal* rights include the right to an *external review*.

Expedited Appeal

You can file an expedited *appeal* when a requested service involves a situation that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. This type of *appeal* must be documented with clinical information.

You may request an expedited *appeal* at any time. You may start the *appeal* by phone or in writing. You may call Member Services to initiate an expedited *appeal* request.

We will make a decision about the request within 72 hours. We will notify you and your *authorized representative* of the result.

External Review

If you, or your *authorized representative*, are not satisfied with the final outcome of the internal *appeal*, an *external review* by an i*ndependent review organization (IRO)* or by the superintendent of insurance, or both, may be requested. You, or your *authorized representative*, can request an *external review* when the *appeal* is of *adverse benefit determinations* based on *medical necessity*, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria. Filing an *external review* will not affect your health care services. We want to know your concerns so we can improve our services. An *external review* decision is binding on us. An *external review* decision is binding on the claimant except to the extent the claimant has other remedies available under *applicable law*. We will pay for the costs of the *external review* performed by the independent reviewer.

All requests for an *external review* must be made within 180 calendar days of the date of the notice of our final *adverse benefit determination*. Standard requests for an *external review* must be provided in writing; requests for expedited *external reviews*, including *experimental*/*investigational*, may be submitted orally or electronically. When an oral or electronic request for review is made, written confirmation of the request must be submitted to us no later than five calendar days after the initial request was made. If the superintendent or *IRO* requires additional information from you or your health care provider, we will tell you what is needed to make the request complete. The *IRO* assigned to review an *adverse benefit determination* shall provide written notice of its decision to either uphold or reverse the determination within 30 calendar days of receipt by the health plan issuer of a request for a standard review or a standard review involving an *experimental* or *investigational* treatment.

You may file the request for an *external review* by contacting us:

Ambetter from Buckeye Health Plan
Attn: Appeals Department
4349 Easton Way, Suite 120
Columbus, OH, 43219
Fax: 1-866-258-4102

You may also request an *external review* by calling Member Services.

Urgent Request for an External Review

If an expedited *external review* (urgent) was requested, the *IRO* will provide a determination as soon as possible or within 72 hours of receipt of the expedited request.

Non-urgent Request for an External Review

Unless the request is for an expedited *external review*, we will initiate an *external review* within five calendar days after it receives your written request if your request is complete. We will provide you with notice that it has initiated the *external review* that includes:

1. The name and contact information for the assigned *independent review organization* or the superintendent of insurance, as applicable, for the purpose of submitting additional information; and
2. Except for when an expedited request is made, a statement that you may, with ten business days after the date of receipt of the notice, submit, in writing, additional information for either the *independent review organization* or the superintendent of insurance to consider when conducting the *external review*.

If your request is not complete, we will notify you in writing and include information about what is needed to make the request complete.

If we deny your request for an *external review* on the basis that the *adverse benefit determination* is not eligible for an *external review*, we will notify you, in writing, the reasons for the denial and that you have a right to *appeal* the decision to the superintendent of insurance.

If we deny your request for an *external review* because you have failed to exhaust the Appeals and Grievance Procedure, you may request a written explanation, which we will provide to you within ten calendar days of receipt of your request, explaining the specific reasons for its assertion that you were not eligible for an *external review* because you did not comply with the required procedures.

Request for *external review* to the Department of Insurance: If we deny your request for an *external review*, you may file a request for the superintendent of insurance to review our

decision by contacting Consumer Services Division at 1-800-686-1526 between 8:00 a.m. and 5:00 p.m., eastern standard time or by sending a written request addressed to:

Consumer Services
The Ohio Department of Insurance
50 West Town St.
Suite 300
Columbus, Ohio 43215

Information about *external reviews* is also available on the Department's website: insurance.ohio.gov.

If the DOI upholds our decision: If you file a request for an *external review* with the DOI, and if the DOI upholds our decision to deny the *external review* because you did not follow our *appeals* and *grievance* procedures, you must resubmit your *appeal* according to our *appeals* and *grievance* procedures within ten calendar days of the date of your receipt of the superintendent's decision. The clock will begin running on all of the required time periods described in the *appeals* and *grievance* procedures when you receive this notice from the superintendent.

If our failure to comply with its obligations under the *appeals* and *grievance* procedures was considered (i) de minimis, (ii) not likely to cause prejudice or harm to you (claimant), (iii) because we had a good reason or our failure was caused by matters beyond our control (iv) in the context of an ongoing good-faith exchange of information between us and you (claimant) or your *authorized representative* and (v) not part of a pattern or practice of our not following the *appeals* and *grievance* procedures, then you will not be deemed to have exhausted the *appeals* and *grievance* requirements. You may request an explanation of the basis for the plan's asserting that its actions meet this standard.

Expedited *external review* for *experimental* and/or *investigational* treatment: You may request an *external review* of an *adverse benefit determination* based on the conclusion that a requested health care service is *experimental* or *investigational*, except when the requested health care service is explicitly listed as an excluded benefit under the terms of the health benefit plan.

To be eligible for an *external review* under this provision, your treating *physician* shall certify that one of the following situations is applicable:

1. Standard health care services have not been effective in improving your condition;
2. Standard health care services are not medically appropriate for you; or
3. There is no available standard health care service covered by the health plan issuer that is more beneficial than requested health care service.

The request for an expedited *external review* under this provision may be requested orally or electronically. For expedited/urgent requests, your health care provider can orally make the request on your behalf.

If we reverse our decision: If we decide to reverse our adverse determination before or during the *external review*, we will notify you, the *IRO*, and the superintendent of insurance within one business day of the decision.

After receipt of health care services: No expedited review is available for *adverse benefit determinations* made after receipt of the health care service or services in question.

Emergency medical services: If we deny coverage for an emergency medical service, we will also advise at the time of denial, that you can request an expedited internal and *external review* of our decision.

Review by the Department of Insurance: If we have made an *adverse benefit determination* based on a *contractual* issue (e.g., whether a service or services are covered under your *contract* of insurance), you may request an *external review* by the department of insurance.

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

Grievances

A *grievance* or *complaint* is an expression of dissatisfaction regarding our products or services. You or your *authorized representative* may submit a *grievance* verbally or in writing. A *grievance* may be filed for issues including quality of care, *physician* behavior, waiting time for services, and involuntary disenrollment. You have up to 180 calendar days to file a *grievance*. The 180 calendar days start on the date of the situation you are not satisfied with. Depending on the nature of the *grievance* and whether or not a response is requested, we will respond verbally and/or in writing within 30 business days following receipt of the *grievance* or should a *member's* medical condition necessitate an expedited review and decision within 48 hours.

Filing a Grievance

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

Ambetter from Buckeye Health Plan
Attn: Grievances Department
PO Box 10341
Van Nuys, CA 91410
Fax: 1-833-866-7956
Telephone: 1-877-687-1180 (TTY 1-877-941-9231)

If filing a written *grievance*, please include:

1. Your first and last name;
2. Your Member ID number;
3. Your address and telephone number;
4. Details surrounding your concern; and
5. Any supporting documentation.

Process and Resolution Timeframes

We will acknowledge your *grievance* by sending you a letter within three business days of receipt of your *grievance*. *Grievances* will be promptly investigated and will be resolved within

30 calendar days of receipt. We will notify you in writing within two business days of the decision. The time period may be extended for an additional 14 calendar days, making the maximum time for the entire *grievance* process 44 calendar days if we provide you or your *authorized representative*, if applicable, written notification of the following within 30 calendar days:

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

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

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

Appeals and Grievances Filing, External Review, and Key Communication Timelines

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

GENERAL PROVISIONS

Entire Contract

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

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

Non-Waiver

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

Rescissions

No misrepresentation of fact made regarding a *member* during the enrollment application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:

1. The misrepresented fact is contained in a written enrollment application, including amendments, signed by a *member*;
2. A copy of the enrollment application, and any amendments, has been furnished to the *member*(s), or to their beneficiary;
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; and
4. The *member* must be provided at least 30 calendar days’ notice before rescinding coverage.

Repayment for Fraud, Misrepresentation, or False Information

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

Conformity with Applicable Laws

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

Hold Harmless

Ambetter from Buckeye Health Plan is not a *member* of any guaranty fund, and in the event that we become insolvent, *member* is protected only to the extent that the hold harmless provision under Ohio Revised Code Section 1751.13 applies to those health care services rendered.

In addition, in the event we become insolvent, the *member* may be financially responsible for health care services rendered by a provider or health care facility that is not under *contract* with us. However, the *member* is protected only to the extent that the hold harmless provision under Ohio Revised Code Section 1751.13 applies to those health care services rendered.