ambetter of Oklahoma





2027 EVIDENCE OF COVERAGE

Ambetter + Adult Vision +Adult Dental





AmbetterHealth.com/en/OK

AMBETTER OF OKLAHOMA

Ambetter + Adult Vision +Adult Dental

Home Office: 14000 Quail Springs Parkway, Suite 650, Oklahoma City, OK 73134

Major Medical Expense Insurance Policy

In this *policy*, the terms "you" and “your” will refer to the *dependent members* enrolled in this *policy*. The terms "we," "our" or "us" will refer to Ambetter of Oklahoma.

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

Guaranteed renewable means that this *policy* will renew each year on the anniversary date unless terminated earlier in accordance with *policy* terms. You may keep this *policy* in force by timely payment of the required premiums. However, we may decide not to renew the *policy* as of the renewal date if: (1) we decide not to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where you then live; (2) we withdraw from the *service area*; or (3) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *policy* benefits.

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

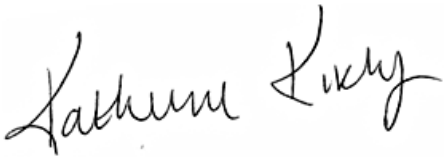
At least 45 calendar days’ notice of any plan to take an action or make a change permitted by this clause will be delivered to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under this *policy* or a change in a *member’s* health. While this *policy* is in force, we will not restrict coverage already in force. If we discontinue offering and decide not to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 90 calendar days prior to the date that we discontinue coverage.

This *policy* contains *prior authorization* requirements. Benefits may be reduced or not covered if the requirements are not met. Please refer to the *Schedule of Benefits* and the Prior Authorization section.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance *policy* containing any false, incomplete, or misleading information is guilty of a felony

RIGHT TO RETURN POLICY

Please read your *policy* carefully. If you are not satisfied, return this *policy* to us or to our agent within ten calendar days after you receive it. All premiums paid will be refunded, less claims paid, and the *policy* will be considered null and void from the *effective date*. If we do not refund the premiums paid within 30 calendar days of the cancellation request, we will pay interest on those proceeds as required by state law.



Katherine W. Kirby,
President

SPECIAL NOTICE OF PROTECTION PROVIDED BY OKLAHOMA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Oklahoma Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Oklahoma law, which determines who and what is covered and the amounts of coverage. The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

Life Insurance

- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance

- $500,000 in *hospital*, medical and surgical insurance benefits
- $300,000 in disability income insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $300,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except that with regard to *hospital*, medical and surgical insurance benefits, the maximum amount that will be paid is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a *policy* or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance *policy* or a variable annuity contract. There are also various residency requirements and other limitations under Oklahoma law.

To learn more about the above protections, please visit the Association's website at **www.oklifega.org**, or contact: Oklahoma Life & Health Insurance Guaranty Association 201 Robert S. Kerr, Suite 600 Oklahoma City, OK 73102 Phone (405) 272-9221	Oklahoma Insurance Department 400 NE 50th Street Oklahoma City, OK 73105 1-800-522-0071 or (405) 521-2828

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INTRODUCTION

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

This *policy*, your *Schedule of Benefits*, and the enrollment application, as submitted to Ambetter of Oklahoma and any amendments or riders attached, shall constitute the entire contract under which *covered services* and supplies are provided or paid for by us.

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

How to Contact Us

Contact us at:

Ambetter of Oklahoma
14000 Quail Springs Parkway, Suite 650
Oklahoma City, OK 73134

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

Member Services..... **1-833-492-0679**
TTY line..... **711**
Fax..... **1-833-959-3364**
Emergency..... **911**
Suicide and Crisis Lifeline. **988** (call or text)
24/7 Nurse Advice Line…... **1-833-492-0679** or for the hard of hearing TTY **711**

Interpreter Services

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

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

To arrange for interpreter services, please call Member Services.

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

If you have difficulty locating a *primary care physician* ("*PCP*"), *specialist physician*, *hospital* or other contracted provider please contact us so that 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-contracted *hospitals*. Your coverage requires you to use contracted providers with limited exceptions. You can access the online directory at AmbetterHealth.com/en/ok.

You have the right to:

1. Participate with your *physician* and *medical practitioners* in making 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 who is 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 *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* can tell you about treatments that may or may not be covered by the *policy*, regardless of the cost. You have a right to know about any costs you will need to pay. This should be told to you in words you can understand. When it is not appropriate to give you information for medical reasons, the information can be given to a legally *authorized representative*. Your *physician* will ask for your approval for treatment unless there is an emergency, and your life and health are in serious danger.

8. Voice *complaints* or *grievances* about our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
9. See your medical records.
10. Be kept informed of covered and non-covered services, program changes, how to access services, *primary care physician* assignment, providers, advance directive information, *authorizations*, benefit denials, *member* rights and responsibilities, and our other rules and guidelines. We will notify you at least 60 calendar days before the *effective date* of the modifications. Such notices shall include:
    a. Any changes in clinical review criteria; or
    b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
11. A current list of *network providers*.
12. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
13. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, ethnicity, race, religion, gender, sexual orientation, national origin, physical or mental disability, or expected health or genetic status.
14. Access *medically necessary* urgent and *emergency services* 24 hours a day and seven days a week.
15. Receive information in a different format in compliance with the Americans with Disabilities Act if you have a disability.
16. Refuse treatment to the extent the law allows without jeopardizing future treatment and be informed by your provider(s) of the medical consequences. You are responsible for your actions if treatment is refused or if the *primary care physician's* instructions are not followed. You should discuss all concerns about treatment with your *primary care physician*. Your *primary care physician* can discuss different treatment plans with you, if there is more than one option that may help you. You will make the final decision.
17. Select your *PCP* within the *network*. You also have the right to change your *PCP* or request information on *network providers* close to your home or work.
18. Know the name and job title of people giving you care. You also have the right to know which *physician* is your *primary care physician*.
19. An interpreter when you do not speak or understand the language of the area.
20. A second opinion by a *network physician* if you want more information about your treatment or would like to explore additional treatment options.
21. Make advance directives for health care decisions. This includes planning treatment before you need it. Advance directives are forms you can complete to protect your rights for medical care. It can help your *primary care physician* 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 *policy* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about your health that we or your *medical practitioners* need in order to provide care. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your *physician* until you understand the care you are receiving.
4. Review and understand the information you receive about us. You need to know the proper use of *covered services*.
5. Show your *member* identification card and keep scheduled appointments with your *physician* and call the *physician’s* office during office hours whenever possible if you have a delay or cancellation.
6. Know the name of your assigned *primary care physician*. You should establish a relationship with your *physician*. You may change your *primary care physician* verbally or in writing by contacting Member Services.
7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
8. Understand your health problems and participate, along with your health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Follow the treatment plans and instructions for care that you have agreed on with your health care professionals and *physician*.
10. Tell your health care professional and *physician* if you do not understand your treatment plan or what is expected of you. You should work with your *primary care physician* to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.
11. Follow all health benefit plan guidelines, provisions, policies, and procedures.
12. Use any emergency room only when you think you have a medical emergency. For all other care, you should call your *primary care physician*.
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 us.
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 *policy* within 60 calendar days of the event. Enrollment related changes include the following: birth of a child, adoption, marriage, divorce, change of address, adding/removing a dependent, *spouse*/domestic partner becomes eligible under a different insurer, or incarceration where *member* cost share would need to transfer from one *policy* to another *policy*.

IMPORTANT INFORMATION

Provider Directory

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

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

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

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

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

Member Identification Card

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

Website

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

1. Finding a *network provider*, including *hospitals* and pharmacies.
2. Our programs and services, including programs to help you get and stay healthy.
3. A secure portal for you to check the status of your claims, make payments and obtain a copy of your *member* identification card.

4. Member Rights and Responsibilities.
5. Notice of Privacy Practices.
6. Current events and news.
7. Our formulary or *prescription drug* list.
8. *Deductible* and *copayment* accumulators.
9. Selecting a *PCP*.

Quality Improvement

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

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

For example, if you have a concern about the care you received from your *network 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 healthcare and services you are receiving.

Protection from Balance Billing

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

DEFINITIONS

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

Wherever used in this *policy*:

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

Acute rehabilitation means *rehabilitation* for patients who will benefit from an intensive, multidisciplinary *rehabilitation* program. Patients normally receive a combination of therapies such as physical, occupational and speech therapy as needed and are medically managed by specially trained *physicians*. *Rehabilitation* services must be performed for three or more hours per day, five (5) to seven days per week, while the *member* is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *skilled nursing facility*.

Advance premium tax credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the 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 a 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 a determination by us which results in:

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

*Adverse benefit determination*s also include a determination that *balance billing protections* do not apply to a service or an incorrectly calculated amount of *cost sharing* a *member* owes when *balance billing protections* apply.

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

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

Please note, if you receive 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 *balance billed* when *balance billing protections* apply to *covered services*. However, you will not be responsible for *balance billing* for non-network care that is subject to *balance billing protections* and otherwise covered under your *policy*. See *balance billing*, *balance billing protections* and *non-network provider* definitions for additional information. If you are *balance billed* in these situations, please contact Member Services immediately at the number listed on the back of your *member* identification card.

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

Ambulatory surgical center means any facility with a medical staff of 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* to reverse, rescind, or otherwise modify an *adverse benefit determination*.

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

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

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

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 a covered individual has given express, written consent to represent that individual in an internal *appeals* process or external review process of an *adverse benefit determination*;
2. A person *authorized* by law to provide substituted consent for a covered individual;
3. A family member 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 service expense. *Network providers* may not *balance bill* you for *covered service expenses* beyond your applicable *cost sharing* amounts.

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

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

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

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

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

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

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

Care management means a program in which a registered nurse or licensed mental health professional, known as a case 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*.

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

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

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

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

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

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

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

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

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

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

Covered service or ***covered service expenses*** means an expense or service that is:

1. Incurred while your or your dependent's insurance is in force under this *policy*;
2. Covered by a specific benefit provision of this *policy*; and
3. Not excluded anywhere in this *policy*.

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

Custodial care includes but is not limited to the following:

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

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

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

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

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

Dental services means *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 *policy* for *covered services*.

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

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

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

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

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

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

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

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

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

will not be a *covered service* unless we authorize the continuation of care, and it is *medically necessary*.

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

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

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

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (FDA) regulation, regardless of whether the trial is subject to FDA oversight;
2. An *unproven service*;
3. Subject to FDA approval, and:
    a. It does not have FDA approval;
    b. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation;
    c. It has FDA approval, but is being to treat a condition, or for a use that is not listed on the Premarket Approval issued by the FDA or has not been determined through peer reviewed medical literature to treat the medical condition of the *member*, or
    d. It has FDA approval but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of an FDA-approved drug is a use that is determined by us to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
        iii. Not an *unproven service*.
4. *Experimental* or *investigational* according to the provider's research protocols.

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

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

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

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

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

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

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

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

Home health care means care or treatment of an *illness* or *injury* at the *member's* home that is 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 *generally accepted standards of medical practice* for the *injury* or *illness* requiring the *home health care*.

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

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

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 *members* 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; a *skilled nursing 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*, *skilled nursing facility*, or *residential treatment facility*, halfway house, or transitional facility, or a patient is moved from the emergency room in a short-term observation status, a *member* will be deemed not to be confined in a *hospital* for purposes of this *policy*.

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

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

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, 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.

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 *policy*. A loss must occur while the *member* is insured under this *policy*.

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

Maximum out-of-pocket amount means the maximum amount a *member* must pay towards *covered services* in the form of *cost sharing* in a given plan year. Once the *maximum out-of-pocket amount* is reached, we will pay one hundred percent of the *allowed amount* for *covered services* received under this *policy*. A *member's deductible amount*, *prescription drug deductible amount* (if applicable), *copayment amounts*, and *coinsurance amounts* all contribute towards the *maximum out-of-pocket amount*. The individual and family *maximum out-of-pocket amounts* are shown in your *Schedule of Benefits*.

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

Medical practitioner means, but is not limited to, a *physician*, nurse anesthetist, *physician's* assistant, physical therapist, licensed mental health and *substance use* practitioners, nurse practitioners, audiologists, chiropractors, dentists, pharmacists, nurse anesthetists, optometrists, podiatrists, psychologists, home care agencies, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy*: acupuncturist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, emergency medical technician, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*, a *medical practitioner*, other health care providers or facilities must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

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

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

Member means an individual covered by the health plan including any 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 and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

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

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

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

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

Network means a group of *medical practitioners* and providers who have contracts that include an agreed upon price for health care expenses.

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

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

Non-elective cesarean section means 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 identified in the most current list for the network shown on your *member* identification card.

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

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

5. The *non-network provider* provides the *member* the notice document and the consent document together, but physically separate from other documents.
6. The *non-network provider* provides the *member* a copy of the signed written *notice and consent* through email or mail.

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

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

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

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

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

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

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

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

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

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

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

Prescription 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 provider who gives or directs health care services for you. *PCPs* includes a family practitioner, general practitioner, advanced practice registered nurses (APRN), *physician* assistant (PA), pediatrician, internist, obstetrician, gynecologist, or any other practice allowed under the *policy*. A *PCP* supervises, directs, and gives initial care and basic medical services to you and is in charge of your ongoing care.

Prior authorization means a decision to approve specialty or other *medically necessary* care for a *member* by the *member's PCP* or provider group prior to the *member* receiving services. *Prior authorization* applies to health care services, treatment plans, *prescription drugs* or *durable medical equipment*.

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

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

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

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

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

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

Rehabilitation or ***rehabilitation services*** 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 therapy*. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been medically *stabilized* and begins to receive *rehabilitation therapy*.

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 *members* 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 in outpatient or *inpatient* setting.

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

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

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

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

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

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

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

Service area means a geographical area, made up of counties, where we have been authorized by the State of Oklahoma to sell and market our health plans. This is where the majority of our *network providers* are located where you will receive all of your health care services and supplies.

Skilled nursing facility means an institution, or a distinct part of an institution, that:

1. Is licensed as a *hospital*, *skilled nursing facility*, or *rehabilitation facility* by the state in which it operates;

2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *physician* and the direct supervision of a registered nurse;
3. Maintains a daily record on each patient;
4. Has an effective *utilization review* plan;
5. Provides each patient with a planned program of observation prescribed by a *physician*; and
6. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing standards of medical practice for that condition.

Skilled nursing facility does not include a facility primarily for rest, the aged, treatment of *substance use*, *custodial care*, nursing care, or for care of *mental health disorders* or the mentally disabled.

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

Specialist or ***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*. *Specialists* may be needed to diagnose, manage, or treat certain types of symptoms and conditions related to their specific field of expertise.

Spouse means the person to whom you are lawfully married.

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

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

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

Substance use disorder means a condition that falls under any of the diagnostic categories listed as a mental or behavioral disorder due to psychoactive substance use (or equivalent category) in the mental, behavioral and neurodevelopmental disorders chapter of the most 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* uses her own egg that is fertilized by a donor, or is a gestational carrier who has a fertilized egg placed in her body, but the egg is not her own.

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

Synchronization means the coordination of medication refills for a patient taking two or more medications for one or more chronic conditions such that the patient's medications are refilled on the same schedule for a given time period.

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

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

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

Third-party means a person or other entity that is or may be obligated or liable to the *member* for payment of any of the *member's* expenses for *illness* or *injury*. The term "*third-party*" includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. However, the term "*third-party*" will not include any insurance company with a *policy* under which the *member* is entitled to benefits as a named insured person or an insured dependent 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 the enrollment application for this *policy* was completed by the *member*, including all *tobacco* and *nicotine* products, e-cigarettes, or vaping devices, but excluding religious and ceremonial uses of *tobacco*.

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

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

1. "Well-conducted randomized controlled trials" means that two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received; and
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 services* benefit for virtual urgent care and virtual *behavioral health* provided to *members* through the *Ambetter-designated telehealth provider*. These services can be accessed through the *Ambetter-designated telehealth provider's* website.

DEPENDENT MEMBER COVERAGE

Dependent Eligibility

Your dependents become eligible for insurance on the latter of:

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

Effective Date for Initial Dependent Members

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

Coverage for a Newborn Child

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

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

Coverage for an Adopted Child

An adopted child of a *member* shall be covered from the date of the filing of a petition for adoption if (1) the *member* applies for coverage within 60 calendar days after the filing of the petition for adoption and where the issuer is notified by the Marketplace and (2) premium billed for this 60-calendar day period is timely paid under the terms of this *policy* and its grace period after such application. However, the coverage shall begin from the moment of birth if (1) the petition for adoption and application for coverage is filed within 60 calendar days after the birth of the child, and (2) premium billed for this 60-calendar day period is timely paid under the terms of this *policy* and its grace period after such application. 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.

Unless an enrollment application is received within 60 calendar days of petition of adoption, and premium is timely paid for the first 60 calendar days under the terms of this *policy* and its grace period, coverage for the adopted child will not be effective and the adopted child cannot be enrolled

until the next open enrollment period. Coverage for an adopted child shall terminate upon the dismissal or denial of a petition for adoption.

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

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

Adding Other Dependent Members

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

ELIGIBILITY AND ENROLLMENT

For All Members

A *member's* eligibility for insurance under this *policy* 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 *primary subscriber* resides outside the *service area* or moving permanently outside the *service area* of this *policy*;
3. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact;
4. The date of termination that the Health Insurance Marketplace provides us upon your request of cancellation to the 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;
5. The date we decline to renew this *policy*, as stated in the Discontinuance provision;
6. The date of a *member's* death; or
7. The date a *member's* eligibility for insurance under this *policy* ceases due to losing *network* access as the result of a permanent move.

If you have material modifications (examples include a change in life event such as marriage, death, or other change in family status), or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Marketplace) at Healthcare.gov or 1-800-318-2596.

For Dependent Members

A dependent will cease to be a *member* at the end of the premium period in which the *member* ceases to be your dependent due to divorce or if a child ceases to be an *eligible child*. For *eligible children*, the Marketplace will send a termination letter with an *effective date* the last day of the dependent's 26th birth month.

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.

The policyholder must provide notification and proof of the incapacity or dependency to us at our request and expense.

There is no time limit for the policyholder to provide notification that their incapacitated dependent has reached the age limit.

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 of January 1st of the following year.

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

Special Enrollment Periods

In general, a *qualified individual* has 60 calendar days to report certain life changes, known as "qualifying events," to 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 member* 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 *qualified health plan* (*QHP*);
7. A *member* or dependent member enrolled in the same plan has a change in eligibility for cost sharing reductions.
8. A *qualified individual* or 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);
9. A *qualified individual*, *member*, or dependent gains access to new *QHP*s as a result of a permanent move, and had *minimum essential coverage* as described in 26 CFR 1.5000A–1(b) for one or more calendar days during the 60 calendar days preceding the date of the permanent move;

10. A *qualified individual* or dependent who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a plan, or change from one plan to another one time per month;
11. A *qualified individual* or *member* demonstrates to 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;
12. A *qualified individual*, *member*, or dependent is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B–2, and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
13. A *qualified individual* or dependent is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 calendar days after the qualifying event; or applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;
14. A *qualified individual* newly gains access to an employer sponsored Individual Coverage Health Reimbursement Arrangement (ICHRA) (as defined in 45 CFR 146.123(b)) or a Qualified Small Employer Health Reimbursement Arrangement (QSHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code);
15. At the option of 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;
16. A *qualified individual* or dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions or government subsidies completely cease;
17. A *qualified individual* 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.

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

1. Experiences a decrease in household income;
2. Is newly determined eligible by the Exchange for advance payments of the premium tax credit; and
3. Had *minimum essential coverage* as described in 26 CFR 1.5000A-1(b) for one or more days during the 60 calendar days preceding the date of the financial change.

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

If you are currently enrolled in Ambetter of Oklahoma, 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:

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

If a *qualified individual*, *member*, or dependent loses coverage, gains access to a new *QHP*, becomes newly eligible for enrollment in a *QHP*, becomes newly eligible for advance payments of the premium tax credit in conjunction with a permanent move, or is enrolled in COBRA continuation coverage and employer contributions to or government subsidies completely cease, and if the plan selection is made on or before the 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 *policy*, and prior coverage terminating immediately before the *effective date* of this *policy* furnishes benefits for the hospitalization after the termination of prior coverage, then services and benefits will not be covered under this *policy* for that *member* until the *member* is discharged from the *hospital* or benefits under the prior coverage are exhausted, whichever is earlier.

If there is no prior coverage or no continuation of *inpatient* coverage after the *effective date*, your Ambetter coverage will apply for *covered services* related to the *inpatient* coverage after your *effective date*. Ambetter coverage requires you notify Ambetter within two calendar days of your

effective date so we can review and authorize *medically necessary* services. If services are at a non-contracted *hospital*, claims will be paid at the Ambetter allowable, and you may be billed for any balance of costs above the Ambetter allowable.

PREMIUMS

Premium Payment

Each premium is to be paid 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:

Premium payments are due in advance, on a calendar month basis. Monthly payments are due before the first calendar day of each month for coverage effective during such month. After the first premium is paid, a three-month grace period starting from the premium due date is given for the payment of premium. 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. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last calendar day of the first month during the grace period if *advance premium tax credits* are received.

We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. We will notify 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. A *member* is not eligible to re-enroll once terminated, unless a *member* has a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

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

Premium payments are due in advance, on a calendar month basis. Monthly payments are due before the first calendar day of each month for coverage effective during such month. After the first premium is paid, a 60-calendar day grace period starting from the premium due date is given for the payment of premium. 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. Coverage will remain in force during the grace period; however, claims may pend for *covered services* rendered to the *member* during the grace period. We will notify the *member*, as well as providers, of the possibility of denied claims when the *member* is in the grace period.

Third-Party Payment of Premiums or Cost Sharing

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

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

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

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

Misstatement of Age

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

Change or Misstatement of Residence

If you change your *residence*, you must notify the Marketplace of your new *residence* within 60 calendar days of the change. As a result, your premium may change, and you may be eligible for a Special Enrollment Period. See the special enrollment periods provision for more information.

Misstatement of Tobacco Use

The answer to the *tobacco* or *nicotine* question on the enrollment application is material to our correct underwriting. If a *member's use of tobacco* or *nicotine* has been misstated on the *member's* enrollment application for coverage under this *policy*, we have the right to rerate the *policy* back to the original *effective date*.

UTILIZATION MANAGEMENT

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

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

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

Authorization Requirements

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

For services or supplies that require prior authorization, as shown in the *Schedule of Benefits*, you must obtain authorization from us.

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*) can be submitted by your provider electronically or via telephone, eFax, or provider web portal. Although not required, submitting requests within the recommended timeframes below will allow for timely review of *authorization* requests:

1. At least five calendar days prior to an elective admission as an *inpatient* in a *hospital*, extended care or *rehabilitation facility*, *hospice*, 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 *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 72 hours of receipt of request.

2. For urgent pre-service reviews, within three calendar days of receipt of the request.
3. For urgent pre-service, within one calendar day from date of receipt of the request.
4. For non-urgent pre-service, within three calendar days from date of receipt of the request.
5. For non-urgent pre-service reviews, within seven calendar days of receipt of the request.
6. 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*.

How to Obtain Prior Authorization

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

Failure to Obtain Prior Authorization

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

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

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

Authorization Does Not Guarantee Benefits

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

Denial of Authorization

Refer to the Appeals and Grievances Procedures section of this *policy* for information on your right to *appeal* a denied *authorization*.

Requests for Predeterminations

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

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

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

COST SHARING FEATURES

Cost Sharing Features

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

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

Deductible

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

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

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

Copayments

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

Coinsurance Percentage

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

Maximum Out-of-Pocket

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

A *member's* maximum out-of-pocket will not exceed the individual *maximum out-of-pocket amount*.

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

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

The amount payable will be subject to:

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

Please refer to the applicable *deductible amounts*, *coinsurance amounts*, and *copayment amounts* on your *Schedule of Benefits*.

Non-Network Liability and Balance Billing

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

ACCESS TO CARE

Primary Care Physician (PCP)

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

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

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

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

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

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

Contacting Your Primary Care Physician

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 appointment, call 24 hours in advance. At every appointment, make sure you bring your *member* identification card and photo identification.

Should you need care outside of your *PCP's* office hours, you should call your *PCP's* office for information on receiving after hours care in your area. If you have an urgent medical problem or question or cannot reach your *PCP* during normal office hours, call our 24/7 nurse advice line at 1-833-492-0679 (TTY: 711). A licensed nurse is always available and ready to answer your health questions. If you are experiencing an *emergency condition*, call 911 or for a *behavioral health emergency condition*, call 988 or go to the nearest emergency room.

Coverage Under Other Policy Provisions

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

Non-Emergency Services Outside of Service Area

If you are traveling outside of the Oklahoma *service area*, you may be able to access providers in another state if there is an Ambetter plan located in that state. You can locate Ambetter providers outside of Oklahoma by searching the relevant state and the plan you are enrolled in on our Provider Directory at Guide.AmbetterHealth.com. Not all states have Ambetter plans. If you receive care from an Ambetter provider outside of the *service area*, you may be required to receive *prior authorization* for non-*emergency services*. Contact Member Services at the phone number on your *member* identification card for further information. Except for emergency health services or services for *dependent members* residing outside the *service area*, if a *member* wishes to receive benefits for *covered services* from a *non-network provider* located outside the *service area*, then the *member* must ensure that the *non-network provider* located outside of the *service area* requests *prior authorization* for the services or supplies. We will apply our Medical Coverage Policies when evaluating *medical necessity* for *non-network providers* services located outside of the *service area*, which includes considering the absence of or the exhaustion of all *network* resources. Failure to request *prior authorization* will result in denial of coverage. *Prior authorization* does not guarantee payment or assure coverage; all claims for benefits delivered by a *non-network provider* located outside of the *service area* must still meet all other terms, conditions, exclusions, and limitations of coverage.

Emergency Services Outside of Service Area

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

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

Continuity of Care

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

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

New Technology

Health technology is always changing. If we think a new medical advancement can benefit our *members*, we evaluate it for coverage. These advancements include new technology, medical procedures, drugs, devices, and applications of existing technology.

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

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

Preferred Partnership

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

Hospital Based Providers

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

MAJOR MEDICAL EXPENSE BENEFITS

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 and *substance use disorder* services (including *behavioral health* treatment), *prescription drugs*, rehabilitative and *habilitative services* and devices, laboratory services, preventive and wellness services, chronic disease management and pediatric services (including oral and vision care). Essential health benefits provided within this certificate are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime or annual dollar maximum. Coverage is limited to Essential Health Benefits and other benefits as required under *applicable laws*. Services that are not Essential Health Benefits, and are not otherwise required to be covered under *applicable laws,* are not covered under this *policy*.

This *policy* provides coverage for health care services for *members* and dependents. Some services require *prior authorization*. *Copayment*, *deductibles*, and *coinsurance amounts* must be paid to your *network provider* or *non-network provider* at the time services are rendered. *Covered services* are subject to all *policy* provisions, including conditions, terms, limitations, and exclusions. *Covered services* must be *medically necessary* and not *experimental* or *investigational*.

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

Acquired Brain Injury Services

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

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

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

To ensure that appropriate post-acute care treatment is provided, this plan includes coverage for expenses related to periodic reevaluation of the care of a *member* who has incurred an acquired brain injury, has been unresponsive to treatment, is medically stable, and is expected, 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.

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.

Ambulance Services

Air Ambulance Service Benefits

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

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

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

Limitations: Benefits for air ambulance services are limited to:

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

Exclusions:

No benefits will be paid for:

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

Ground and Water Ambulance Service Benefits

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

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

NOTE: 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.
3. Non-emergency transportation (for example- transport van, taxi).

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. Speech therapy;
5. Occupational therapy;
6. Physical therapy;
7. Behavioral health services such as counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor, or clinical social worker;
8. Medications or nutritional supplements used to address symptoms of *autism spectrum disorder;* and
9. *Habilitation services*.

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

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

Care Management Programs

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

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

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

Chiropractic Services

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

Clinical Trial Coverage

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

Coverage will include routine patient care costs incurred for:

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

Clinical trials must meet the following requirements:

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

“Clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, funded or approved by:

1. One of the National Institutes of Health (NIH);
2. The Centers for Disease Control and Prevention;
3. The Agency for Health Care Research and Quality;
4. The Centers for Medicare & Medicaid Services;
5. A cooperative group or center of any of the entities listed above or the Department of Defense or the Department of Veteran Affairs;
6. An NIH Cooperative Group or Center;
7. The FDA in the form of an *investigational* new drug application;
8. The federal Departments of Veterans’ Affairs, Defense, or Energy;
9. An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects;
10. The study or investigation is a drug trial that is exempt from having such an *investigational* new drug application; or
11. A qualified non-governmental research entity that meets the criteria for NIH Center support grant eligibility.

In a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. A *qualified individual* must be eligible to participate in the clinical trial, and either (a) have a referral from a doctor stating that the clinical trial would be appropriate based upon the individual having cancer or a life-threatening disease or condition; or (b) the individual must provide medical and scientific information establishing that their participation in the clinical trial would be appropriate based on the individual having cancer or a life-threatening disease or condition. Participation in clinical trials is subject to *prior authorization* requirements as outlined in this *policy*.

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

Colorectal Cancer Examinations and Laboratory Tests

Covered service expenses include colorectal cancer tests for any non-symptomatic *member*, in accordance with the current American Cancer Society guidelines. *Covered services* includes tests for *members*, who are at least 45 years of age; or less than 45 years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.

Contraception and Family Planning

Family planning/contraception benefits are covered under preventive care, without *cost sharing*, when provided by a *network provider*, when the care is legal under *applicable law*. These benefits may

include the following for adolescent and adult women, in accordance with the most recent guidelines supported by Health Resources and Services Administration (HRSA):

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

For prescription contraceptive drugs 6-month supply is covered at initial fill and any subsequent time the *member* obtains the same drug during each 12-month period.

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.

Dental Benefits – Adults 19 years of age or older

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

1. Diagnostic and Preventive Services — Class 1 benefits include:
    a. Routine cleanings,

b. Oral examinations,
c. X-rays – bitewing, full-mouth, and panoramic film,
d. Topical fluoride application.

2. Basic Services — Class 2 benefits include:
   a. Minor restorative – metal or resin-based fillings,
   b. Endodontics – root canals,
   c. Periodontics – scaling and root planning, periodontal maintenance,
   d. Removable prosthodontics – relines, rebase, adjustments and repairs,
   e. Oral *surgery* –non-surgical and surgical extractions.
3. Major Services — Class 3 benefits include:
   a. Fixed prosthodontics - crowns and bridges,
   b. Removable prosthodontics – partial and complete dentures,
   c. Oral *surgery* - impacted and complex extractions, other surgical services.

Services not covered:

1. Dental services that are not medically necessary or specifically covered.
2. Hospitalization or other facility charges.
3. Prescription drugs dispensed in the dental office.
4. Any dental procedure performed solely as a cosmetic procedure.
5. Charges for dental procedures completed prior to the member's effective date of coverage.
6. Services provided by an anesthesiologist.
7. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing or repairing tooth structure lost by attrition (wear), abfraction, abrasion, or erosion, realignment of teeth, periodontal splinting, and gnathologic recordings.
8. Direct diagnostic, surgical or non-surgical treatment procedures applied to jaw joints or muscles.
9. Any artificial material implanted or grafted into soft tissue, surgical removal of implants, and implant services.
10. Sinus augmentation.
11. Surgical appliance removal.
12. Intraoral placement of a fixation device.
13. Oral hygiene instruction, tobacco counseling, nutritional counseling or high-risk substance abuse counseling.
14. Services for teeth retained in relation to an overdenture.
15. Any oral surgery that includes surgical endodontics (apicoectomy and retrograde filling)
16. Analgesia (nitrous oxide).
17. Temporary procedures.

18. Splinting.
19. Temporomandibular joint (TMJ) disorder appliances, therapy, films and arthrograms.
20. Oral pathology laboratory.
21. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete).
22. Veneers (bonding of coverings to the teeth).
23. Orthodontic treatment procedures.
24. Orthognathic surgery.
25. Athletic mouth guards.
26. Space maintainers.

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

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 where such supplies are prescribed by a provider.

Covered service expenses include, but are not limited to:

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

Any additional diabetes equipment, related supplies and health care provider services that are *medically necessary* for the treatment of diabetes as determined on an annual basis by The State Board of Health as being *medically necessary* for the treatment of diabetes will also be *covered service expenses*, subject to the terms of this *policy* and provided any equipment and supplies have been approved by the federal Food and Drug Administration (FDA).

Insulin: The total amount you will be required to pay for a covered insulin medication will not exceed $30 per 30-day supply or $90 per 90-day supply. If your cost share per 30-day supply of insulin medication is less than $30 or 90-day supply of insulin medication is less than $90, you will be responsible for the lower amount. Please refer to our formulary for tier placement of insulin medications and your *Schedule of Benefits* for your cost share responsibility for the associated drug tier.

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 service expenses include:

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

After you receive appropriate training at a dialysis facility we designate, we 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. *Durable medical equipment* and supplies are subject to *prior authorization* as outlined in this *policy*. Please see your *Schedule of Benefits* for benefit levels or additional limits. Repair, adjustment, and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

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

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

1. The equipment, supply or appliance is worn out or no longer functions.
2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by our *durable medical equipment* vendor should be done to estimate the cost of repair.

3. Individual's needs have changed, and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4. The equipment, supply or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include the following:

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

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

Disposable Medical Supplies

Disposable medical supplies, which have a primary medical purpose, are covered and are subject to reasonable quantity limits as determined by us. Examples include, but are not limited to: bandages & 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. The plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are *covered services*. Payment for related supplies is a *covered service* only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the *member*; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered services may include, but are not limited to:

1. Hemodialysis equipment;
2. Crutches and replacement of pads and tips;
3. Pressure machines;
4. Infusion pump for 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. Rental of one Continuous Passive Motion (CPM) machine per *member* following a covered joint *surgery*;
10. The cost of a monofocal lens, if the multifocal lens is implanted after a cataract extraction;

11. Artificial eyes and polishing of such, for larynx, breast prosthesis, or basic artificial limbs. If more than one *prosthetic device* can meet a member's functional needs, only the charge for the most cost-effective *prosthetic device* will be considered a *covered service* expense; and
12. Rental of *medically necessary durable medical equipment*.

Exclusions:

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

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

Medical and Surgical Supplies

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

Covered services may include, but are not limited to:

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

Exclusions:

Non-Covered Services include but are not limited to:

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

Prosthetics

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

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

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

Covered services may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and surgical bras, 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*).

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.

Orthotic Devices

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

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

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

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

Exclusions:

Non-covered services include but are not limited to:

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

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.

Please note, some providers that provide *emergency services* may not be in your *network*. These services are subject to *balance billing protections* and the *non-network provider* may not balance bill you for the difference between our *allowed amount* and their *billed amount*.

Fertility Preservation

We cover standard *medically necessary* fertility preservation services for *members* within reproductive age, diagnosed with cancer, when a medical treatment will directly or indirectly result in "iatrogenic infertility," which is an impairment of fertility by *surgery*, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes. *Cost sharing* such as *deductibles*, *copayments*, and *coinsurance* may be imposed on fertility preservation services if the *cost sharing* is consistent with other benefits in the contract and place of service.

Genetic Testing

Coverage under this provision shall not be subject to any annual deductibles, copayments, or coinsurance limits as established for all covered benefits under this contract. This does not apply to HSA plans – the deductible still applies. Once the deductible is met, no cost share will apply.

1. Clinical genetic testing for an inherited gene mutation for individuals with a personal or family history of cancer when such test provides clinical utility and when ordered or recommended by a health care provider in accordance with medical and scientific evidence, and
2. Evidence-based cancer imaging for individuals with an increased risk of cancer when such test provides clinical utility and when ordered or recommended by a health care provider.

Habilitation Expense Benefits

Habilitative developmental services may be subject to *prior authorization* to determine *medical necessity*. *Covered service expenses* for *habilitation services* include:

1. Physical, occupational and speech therapies; and
2. Developmental services and *durable medical equipment* for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder.

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

Home Health Care Service Expense Benefits

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

1. *Home health aide services* only if provided in conjunction with skilled registered nurse or licensed practical nursing services.
2. Skilled services of a registered nurse or licensed practical nurse rendered on an outpatient basis.
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care*. Please refer to your *Schedule of Benefits* for any limits associated with this benefit.

4. Intravenous. medication and pain medication.
5. Hemodialysis, and/or for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental of *medically necessary durable medical equipment* at our discretion.

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

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

Limitations:

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

Exclusion:

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

Hospice Care Service Expense Benefits

Hospice care benefits are allowable for a *terminally ill member* receiving *medically necessary* care under a *hospice* care program or in a home setting. Benefits for *hospice inpatient*, home and outpatient care is subject to *prior authorization* as outlined in this *policy*.

The list of *covered service* expenses includes:

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

Exclusions and Limitations:

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

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

Hospital Benefits

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

1. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
2. A private *hospital* room when needed for isolation.
3. Daily room and board and nursing services while confined in an *intensive care unit*.
4. *Inpatient* use of an operating, treatment, or recovery room.
5. Outpatient use of an operating, treatment, or recovery room for *surgery*.
6. Services and supplies, including drugs and medicines, which are routinely provided by the *hospital* 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.

Infertility

Covered service expenses under this benefit are provided for *medically necessary* diagnostic and exploratory procedures to determine infertility. In addition, coverage is provided for *surgical procedures* to correct a medically diagnosed disease or condition of the reproductive organs including, but not limited to, treatment of the following:

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

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

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

Long Term Acute Care

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

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

1. Complex wound care:
    a. Daily *physician* monitoring of wound,
    b. Wound requiring frequent complicated dressing changes, and possible repeated debridement of necrotic tissue,
    c. Large wound with possible delayed closure, draining, and/or tunneling or high output fistulas,
    d. Lower extremity wound with severe ischemia,
    e. Skin flaps and grafts requiring frequent monitoring.

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

Lymphedema

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

Mammography Screening

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

Maternity Care

Coverage for maternity care: outpatient and *inpatient* pre- and post-partum care including examinations, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and *hospital* stays for delivery or other *medically necessary* reasons less any applicable *deductible*, or *coinsurance*. An *inpatient* stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a cesarean delivery. We do not require a *physician* or other health care provider to obtain *prior authorization* for delivery. An *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require notification to the health plan.

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

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

Newborn Charges

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

Duty to Cooperate

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

Ambetter of Oklahoma
Attn: Mailroom Department
C/O Surrogacy Forms
P.O. Box 5010
Farmington, MO 63640-5010

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

Newborns' and Mothers' Health Protection Act Statement of Rights

If expenses for *hospital* confinement in connection with childbirth are otherwise included as *covered service expenses*, 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 service expenses* incurred for a shorter stay if the attending provider (e.g., your *physician*, nurse midwife or *physician* assistant), after consultation with the mother, discharges the mother or newborn earlier. In any case, issuers may not, under federal law, require that a provider obtain *prior authorization* from the issuer for prescribing a length of stay not in excess of 48 hours or 96 hours.

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 *authorization* for prescribing a length of stay of up to 48 hours or 96 hours.

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

Medical and Surgical Expense Benefits

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

1. For *surgery* in a *physician's* office, an *inpatient* facility, an outpatient facility, or a surgical facility, including services and supplies.
2. For pre-surgical and post-surgical procedures and testing, including but not limited to, diagnostic services using radiologic, ultrasonographic or laboratory services.
    a. Laboratory tests or radiological examinations done on an outpatient basis in a *hospital* or other facility accepted by the *hospital* before *hospital* confinement or outpatient *surgery* or procedures. The tests must be for the same bodily *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,

3. For medical services in an office or facility that is provided by a licensed *medical practitioner* or *specialist physician*, including consultations and *surgery* related services.
4. For chemotherapy (including oral chemotherapy), inhalation therapy, infusion therapy, and radiation therapy or treatment in a *hospital* or office setting.
5. For *durable medical equipment*, *prosthetic devices*, *orthotic devices*, or other *necessary medical supplies* following a medical or *surgical procedure* such as crutches, orthopedic splints, braces, or casts. Please see the Durable Medical Equipment, Medical and Surgical Supplies, Orthotic Devices and Prosthetics provision of this *policy*.
6. For hemodialysis and the charges by a *hospital* or facility for the processing and administration of genetic testing, blood, or blood components, including cost of blood, blood plasma and blood plasma expanders, which is not replaced by or for you.
7. For the cost and administration of anesthesia, oxygen, drugs, medications, and biologicals.
8. For *medically necessary* reconstructive or cosmetic *surgery* including, but not limited to:
   a. Reconstructive breast *surgery* charges as a result of a partial or total mastectomy. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedema. No timeframes are imposed for inpatient care following a mastectomy for the treatment of breast cancer.
   b. *Reconstructive surgery* for craniofacial abnormalities.
9. For *medically necessary* dental *surgery* due to:
   a. An accidental *injury* which results in damage to natural teeth. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
   b. *Surgery* to correct a functional defect which results from a congenital and/or acquired disease or anomaly.
   c. Cleft lip and cleft palate for an eligible *member*. *Covered services* include medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the treating *physician* or surgeon and such *physician* or surgeon certifies that such services are *medically necessary* and consequent to treatment of the cleft lip or cleft palate.
   d. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* charges for dental care, rendered by a dentist, provided to the following *members*:
      i. A *member* whose treating *medical practitioner* in consultation with the dentist, determines the *member* has a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or,
      ii. A *member* who has one or more medical conditions that would create significant or undue medical risk for the *member* during delivery of any dental treatment or *surgery* if not rendered in a *hospital* or ambulatory surgical center.

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

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.
    a. No timeframes are imposed for inpatient care following the dissection of a lymph node for the treatment of breast cancer.
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 *policy*. See the Clinical Trial Coverage provision of this *policy*.
13. For the following types of *medically necessary* implants and tissue grafts:
    a. Corneal transplants,
    b. Artery or vein grafts,
    c. Heart valve grafts,
    d. Prosthetic tissue replacement, including joint replacements,
    e. Implantable prosthetic lenses, in connection with cataracts,
    f. Skin grafts.
14. For X-rays, Magnetic Resonance Imaging (MRI), Computed Tomography (CAT) scan, Positron Emission Tomography/ Single Photon Emission Computed Tomography (PET/SPECT), and other diagnostic services. See the Radiology, Imaging and Other Diagnostic Testing provision of this *policy*.
15. For *medically necessary telehealth services*. Services not provided by *Virtual 24/7 care* would be subject to the same *cost sharing* as the same health care services when delivered to a *member* in-person.
16. Therapeutic abortion performed to save the life of the *member*, or as required by *applicable law*.
17. For *surgery* or services related to cochlear implants and bone-anchored hearing aids.
18. For *medically necessary* services for complications arising from medical and surgical conditions.
19. For respiratory, pulmonary, cardiac, physical, occupational and speech therapy. Please see Rehabilitation and Extended Care Facility Expense Benefits and Habilitation Expense Benefits provisions.
20. For children’s early intervention therapy for expenses arising from the services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists, and clinical social workers working with children from birth to 36 months of age with an identified developmental disability and/or delay.

21. For *medically necessary* footcare treatment that may require *surgery*; *prior authorization* may be required.
22. For dermatology services which are limited to the following: *medically necessary* minor *surgery*, tests and office visits provided by a dermatologist who is a *network provider*.
23. For *medically necessary* biofeedback services.
24. For services associated with human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation or transplant procedure.
25. For *medically necessary chiropractic care* or manipulative therapy treatment on an outpatient basis only *Covered services* are subject to all other terms and conditions of the *policy*, including the *deductible amount* and *cost sharing* provisions.
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. For elective sterilization procedures (e.g., vasectomies). **Note**: No cost share applies, except for HSA-compatible plans.
29. For a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances:
    a. If such refractive error results from traumatic *injury* or corneal disease, infectious or non-infectious, and
    b. For one pair of eyeglasses or contact lenses per *member* following a covered cataract *surgery*. See your *Schedule of Benefits* for benefit levels or additional limits.
30. For administration of *medically necessary* anesthesia by a licensed *medical practitioner*. No time limits will be imposed on the administration of *medically necessary* anesthesia.
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,
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 facility. 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. For *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 in order to create a more normal appearance.
    i. *Surgery,* excluding tooth extraction, to treat craniomandibular disorders, or malocclusions.
2. Dental service expenses when a member suffers an injury that results in damage to the natural teeth, not to include damage resulting from chewing or parafunctional habit.

Medical Foods and Nutritional Services

We cover medical foods and formulas for:

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

Coverage 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.

We also cover nutritional services for the treatment of cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, or kidney disease. Benefits for medical foods are exempt from any *deductible* requirements.

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

Low-Protein Food Products for Treating Inherited Metabolic Diseases

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

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

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

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 Expense Benefits

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

Covered services will be provided on an *inpatient* and outpatient basis and include mental health and *substance use disorder* diagnoses. If you need mental health and/or substance, use disorder treatment, you may choose any provider participating in our mental health provider *network*. *Deductible amounts*, *copayment* or *coinsurance amounts* and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits. If you have difficulty locating a *behavioral health* provider or other contracted provider related to mental health and *substance use disorder* treatment, please contact us so that we can assist you with accessing or locating a provider.

Deductible amounts, *copayment* or *coinsurance amounts* and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

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

When making coverage determinations, our behavioral health utilization management staff utilizes established level of care guidelines and medical necessity criteria that are based on *generally accepted standards of medical practice* and take into account legal and regulatory requirements. 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 or *substance use disorder* services are as follows:

Inpatient

1. *Inpatient* psychiatric hospitalization;
2. *Inpatient* detoxification treatment;
3. *Inpatient rehabilitation*;
4. Crisis stabilization;
5. *Residential treatment facility* for mental health 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 and *substance use disorders*;
6. Individual, family, and group therapy for mental health disorders and *substance use disorders*;
7. Medication assisted treatment – combines behavioral therapy and medications to treat *substance use disorders*;
8. Medication management services;
9. Psychological and neuropsychological testing and assessment;
10. *Applied behavior analysis (ABA)* therapy;
11. *Telehealth* and Virtual Care Services provided on the same basis and to the same extent (included cost shares) for the provision of in-person health care services (individual/family therapy; medication monitoring; assessment and evaluation);
12. Electroconvulsive therapy (ECT);
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 psychological testing, neuropsychological testing, electroconvulsive therapy, transcranial magnetic stimulation, applied behavior analysis, medication assisted treatment, intensive outpatient programs, partial hospitalization/day treatment (eight hours) and partial hospitalization/half day treatment (four hours), laboratory procedures, and habilitation/rehabilitation services (physical therapy, speech therapy, occupational therapy).

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

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

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

Nutritional Counseling

When deemed *medically necessary* by your provider, nutritional counseling is a covered benefit.

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 *cost sharing* and annual *maximum out-of-pocket* amounts. To see which vision providers are part of the *network*, please visit AmbetterHealth.com/en/ok or call Member Services.

Services not covered:

1. Deluxe frame/frame upgrade;
2. Visual therapy (see medical coverage);

3. Two pairs of glasses as a substitute for bifocals;
4. LASIK and other refractive *surgery*; and
5. Replacement eyewear.

Prescription Drug Expense Benefits

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

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

1. A *prescription drug*.
2. Prescribed, self-administered anticancer medication. **Note**: Coverage is provided in accordance with Oklahoma state law and prescribed orally administered anticancer medications is covered no less favorably than intravenously administered or injected cancer medications.
3. Contraceptive devices prescribed by a *physician*.
4. Any drug that, under the *applicable law*, may be dispensed only upon the written prescription of a *physician*.
5. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one standard reference compendium; or
    b. The drug is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

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

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

Covered service expenses shall include coverage for prescribed drugs or devices approved by the United States Food and Drug Administration for use as a contraceptive.

The appropriate drug choice for a *member* is a determination that is best made by the *member* and the *member's physician*.

Drug Synchronization

Covered service expenses includes the *synchronization* of *prescription drug* refills on at least one occasion per insured per year, provided all of the following conditions are met:

1. The *prescription drugs* have been approved by a formulary exceptions process;
2. The *prescription drugs* are maintenance medications and have available refill quantities at the time of *synchronization*;
3. The medications are not Schedule II, III or IV controlled substances;

4. The insured meets all utilization management criteria to the *prescription drugs* at the time of *synchronization*;
5. The *prescription drugs* are of a formulation that can be safely split into short-fill periods to achieve *synchronization*;
6. The *prescription drugs* do not have special handling or sourcing needs as determined by the plan, contract, or agreement that require a single, designated pharmacy to fill or refill the prescription; and
7. The *member* agrees to the *synchronization*.

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.

Notice and Proof of Loss

In order to obtain payment for *covered service expenses* incurred at a pharmacy for *prescription orders*, a notice of claim and *proof of loss* must be submitted directly to us.

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 a specified location. Ambetter pharmacy, together with Medical Management will review *member* profiles and using specific criteria, will recommend *members* for participation in the lock-in program. *Members* identified for participation in the lock-in program and associated providers will be notified of *member* participation in the program via mail. Such communication will include information on duration of participation, pharmacy to which *member* is locked-in, and any *appeals* rights.

Exclusions and Limitations:

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

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance, unless listed on the formulary;
2. For weight loss *prescription drugs* unless otherwise listed on the formulary;
3. For immunization agents otherwise not required under 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. This exclusion does not apply to prescribed FDA-approved contraceptive methods;

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

Generic Medications

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

Over-the-Counter (OTC) Prescriptions

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

How to Fill a Prescription

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

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

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

Split-Fill Dispensing Program

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

Medication Balance-On-Hand

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

Mail Order Pharmacy/Prescription Drug Delivery

Mail order pharmacy offers a convenient way to receive your prescriptions. Eligible prescriptions will be safely delivered right to your door at no extra charge to you. You will still be responsible for your regular *copayment*/*coinsurance amounts*. 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 *network* mail order pharmacies and next steps for enrollment.

Self-injectable Drugs

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

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 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 option, if a generic medication on the formulary is not suitable for your condition.

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

For the most current Ambetter Formulary or Prescription Drug List or for more information about our pharmacy program visit AmbetterHealth.com/en/ok or call Member Services.

Non-Formulary Prescription Drugs

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

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.

Prescription Drug Exception Process

Standard exception request

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

Expedited exception request

A *member*, a *member’s authorized representative* or a *member’s* prescribing *physician* may request an expedited review based on exigent circumstances. Exigent circumstances exist when a *member* is suffering from a health condition that may seriously jeopardize the *member's* life, health, or ability to regain maximum function or when an *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.

External exception request review

If we deny a request for a standard exception or for an expedited exception, the *member*, the *member’s authorized representative* or the *member’s* prescribing *physician* may request that the original exception request and subsequent denial of such request be reviewed by an independent review organization. We will make our determination on the external exception request and notify the

member, the *member's authorized representative* or the *member's* prescribing *physician* of our coverage determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request if the original request was an expedited exception.

Exception to step therapy of fail first protocol

We will grant an exception to step therapy or fail first protocol when:

1. Treatment for chronic obstructive pulmonary disease (CRF-COPD) will be provided under the following terms:
    a. Any treatments otherwise required under the protocol have not been shown to be as effective as other available options in the treatment of the disease or condition or the participant or beneficiary, when prescribed consistent with clinical indications, clinical guidelines, or other peer-reviewed evidence;
    b. Delay of proven effective treatment would lead to severe or irreversible consequences, and the treatment initially required under the protocol is reasonably expected to be less effective based upon the documented physical or mental characteristics of the participant or beneficiary and the known characteristics of such treatment;
    c. Any treatments otherwise required under the protocol are contraindicated for the participant or beneficiary or have caused, or are likely to cause, based on clinical, peer-reviewed evidence, an adverse reaction or other physical harm to the participant or beneficiary;
    d. Any treatment otherwise required under the protocol has prevented, will prevent, or is likely to prevent a participant or beneficiary from achieving or maintaining reasonable and safe functional ability in performing occupational responsibilities or activities of daily living; or
    e. The patient's disease state is classified as life threatening.
2. Advanced metastatic cancer.

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

Preventive Care Expense Benefits

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

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

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

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

Certain services can be performed for preventive or diagnostic reasons. 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.

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

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

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

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

Notification

As required by section 2715(d)(4) of the Public Health Service Act, we will provide 60 calendar days advance notice to you before any material modification will become effective, including any changes to preventive benefits covered under this *policy*. You may access our website or the Member Services Department at 1-833-510-4727 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/ok.

Prostate Specific Antigen Testing

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

Radiology, Imaging and Other Diagnostic Testing

Medically necessary radiology services, imaging and tests performed for diagnostic reasons are a *covered service* (e.g., X-ray, Magnetic Resonance Imaging (MRI), Computed Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT), mammogram, and 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).

In accordance with state law, any diagnostic examination for breast cancer shall not apply *member* cost share. A diagnostic examination may include, but is not limited to, a diagnostic mammogram, breast magnetic resonance imaging, or a breast ultrasound. Diagnostic examination for breast cancer means a *medically necessary* and clinically appropriate examination, as defined by current guidelines, and as determined by a clinician who is evaluating the individual for breast cancer, to evaluate the abnormality in the breast that is:

1. Seen or suspected from a screening examination for breast cancer,
2. Detected by another means of examination, or
3. Suspected based on the medical history or family medical history of the individual.

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 Extended Care Facility Expense Benefits

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

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

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

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

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

Second Medical Opinion

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

Skilled Nursing Facility Expense Benefits

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

1. Services or confinement in a *skilled nursing facility* must begin within 14 calendar days of a *hospital* stay of at least three consecutive calendar days and be for treatment of, the same *illness* or *injury* that resulted in the *hospital* stay;
2. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital* or *skilled nursing facility* for:
    a. Daily room and board and nursing services;
    b. Diagnostic testing; and
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the United States Food and Drug Administration (FDA).

Skilled nursing facility charges are limited to 30 calendar days per *member* per year. See your *Schedule of Benefits* for benefit levels or additional limits.

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 service expenses for transplant service expenses:

Transplants are a *covered service* when a *member* is accepted as a transplant candidate and obtain *prior authorization* in accordance with this *policy*. *Prior authorization* must be obtained through the *Center of Excellence*, a *network* facility, or in a non-network facility approved by us when there is no *network* adequacy, before an evaluation for 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 *policy* will be provided for both you and the donor. In this case, payments made for the donor will be charged against *member's* benefits.
3. If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this *policy* will be provided for you. However, no benefits will be provided for the recipient.
4. If there is a lapse in coverage due to non-payment of premium, no services related to transplants will be paid as a *covered service*.

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

1. Pre-transplant evaluation;
2. Pre-transplant harvesting of the organ from the donor;
3. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant);
4. Including outpatient *covered services* related to the transplant *surgery*, pre-transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection, and other 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 medically *stabilize* a *member* to prepare for a later transplant, whether or not the transplant occurs;
6. The transplant itself, including the acquisition cost for the organ or bone marrow when authorized through the *Center of Excellence* and services are performed at a participating facility;
7. Post-transplant follow-up visits and treatments;
8. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors; and
9. All costs incurred and medical expenses by the donor; shall be paid under the transplant recipient *policy*, this excludes travel, lodging, food, and mileage. Please refer to the “Member Transplant Travel Reimbursement Policy” for outlined details on reimbursement limitations at AmbetterHealth.com/en/ok.

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

Ancillary *Center of Excellence* Service Benefits:

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

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

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

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 *medically necessary* transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision 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. The acquisition cost for the organ or bone marrow, when provided at an unauthorized facility or not obtained through the *Center of Excellence*.

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

Urgent Care Service Benefits

Urgent care services include *medically necessary* services by *network providers* and services provided at a *network urgent care center* including facility costs and supplies. Care that is needed

after a *PCP's* normal business hours is also considered to be urgent care. Your zero-*cost sharing* preventive care benefits may not be used at an *urgent care center*.

Members are encouraged to contact their *PCP* for an appointment before seeking care from another provider, but *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 1-833-492-0679 (TTY: 711). The 24/7 Nurse Advice Line is available 24 hours a day, seven days a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

Vision Benefits – Adults 19 years of age or older

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

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

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

Services not covered:

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

WELLNESS PROGRAMS AND OTHER OFFERINGS

In connection with this *policy*, we may offer wellness programs and other services to *members* that serve to remove barriers to accessing health services and improve overall health outcomes. These programs and services are available when your coverage begins and 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 *policy* but are not insurance. We may make changes to the terms and conditions of the programs and services or discontinue them at any time. Program tools and 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/ok or by contacting Member Services.

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

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

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

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

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*.
2. For any portion of the charges that are in excess of the eligible service expense.
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*, bariatric *surgery*, except as specifically covered in the Major Medical Expense Benefits section of this *policy*.
4. For weight loss programs, gym memberships, exercise equipment, or meal preparation programs.
5. For the reversal of elective sterilization procedures.
6. For abortion, except as described in the Medical and Surgical Expense Benefits provision under the Major Medical Expense Benefits section.
7. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in the Major Medical Expense Benefits provision.
8. For expenses for television, telephone, or expenses for other *members*.
9. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
10. For telephone consultations between providers, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
11. For stand-by availability of a *medical practitioner* when no treatment is rendered.

12. For dental service expenses, including braces for any medical or dental condition, *surgery*, and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits.
13. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect.
14. For mental health examinations and services involving:
    a. School funded/administered services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
    b. Pre-marital counseling;
    c. Court-ordered care or testing or required as a condition of parole or probation. Benefits will be allowed for services that are *medically necessary* and would otherwise be covered under this *policy*;
    d. Testing of aptitude, ability, intelligence, or interest; and
    e. Evaluation for the purpose of maintaining employment. Benefits will be allowed for services that would otherwise be covered under this *policy*.
15. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the transplant expense benefits.
16. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
17. For *members* while confined primarily to receive *rehabilitation*, *custodial care*, educational care, or nursing services, unless expressly provided for by the *policy*.
18. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*.
19. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the *policy*.
20. 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.
21. For hearing aids, except as expressly provided in this *policy*.
22. For treatment received outside the United States, except for a medical emergency while traveling for up to a maximum of 90 consecutive calendar days.
23. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's* workers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.

24. For *surrogacy arrangement*s. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or using the services of a *surrogate* who may or may not be a *member* including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the *surrogate* following childbirth);
    d. Mental health services related to the *surrogacy arrangement*;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
    h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement* including but not limited to labs, imaging, and diagnostics;
    i. Any complications of the *surrogate* resulting from the *pregnancy*;
    j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*;
    k. Pre-counseling, advice on procreation, or consultations related to gestational carriers or donor services;
    l. Any corrective surgeries or laparoscopic procedures for the sole purpose of surrogacy arrangement; or
    m. Any other medical or healthcare services related to the pregnancy or preparations to become a surrogate or donor.

    Any and all other health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except when the child is the adoptive child of *members* possessing an active *policy* with us and/ or the child possesses an active *policy* with us effective at the time of birth.
25. For fetal reduction *surgery*.
26. For services except as specifically identified as a *covered service expense* under the *policy*, expenses for alternative treatments, including acupressure, acupuncture, aromatherapy, dry needling, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
27. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or semi-professional sports; intercollegiate sports not including intramural sports; racing or speed testing any motorized vehicle or conveyance, if the *member* is paid to participate or to instruct; racing or speed testing any non-motorized vehicle or conveyance, if the *member* is paid to participate or to instruct; rodeo sports; horseback riding, if the *member* is paid to participate or to instruct; rock or mountain climbing, if the *member* is paid to participate or to instruct; or skiing, if the *member* is paid to participate or to instruct.
28. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.

29. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of the *member's* enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
30. For the following miscellaneous items: artificial insemination (except where required by federal or state law); biofeedback; care or complications resulting from non-covered service expenses; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods provision; health club memberships, unless otherwise covered; home test kits, unless required by *applicable law*; care or services provided to a non-member biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *rehabilitation* services for the enhancement of job, athletic or recreational performance; routine or elective care outside the *service area*; treatment of spider veins; transportation expenses; unless specifically described in this *policy*.
31. For diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining, or monitoring employment. Benefits will be allowed for services that would otherwise be covered under this *policy*.
32. For any medicinal and recreational use of cannabis or marijuana.
33. For any non-*medically necessary* court ordered care for a medical/surgical or mental health/*substance use disorder* diagnosis, unless required by state law.
34. For expenses or services related to immunizations and vaccinations for occupational purposes.
35. For expenses for services related to *respite care*.
36. For expenses for services related to massage therapist.
37. For expenses, services, and treatments from a naprapatic *specialists* for conditions caused by contracted, injured, spasmed, bruised, and or otherwise affected myofascial or connective tissue.
38. For expenses, services, and treatments from a naturopathic *specialist* for treatment of prevention, self-healing, and use of natural therapies.
39. For expenses, services, and treatments related to private duty nursing in an *inpatient* location.
40. For vehicle installations or modifications which may include, but are not limited to, adapted seat devices, door handle replacements, lifting devices, roof extensions, and wheelchair securing devices.
41. For Assertive Community Treatment (ACT).
42. For expenses and services for fertility preservation storage.
43. For doula services.
44. 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 Policy

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

1. Non-payment of premiums when due, subject to the Grace Period provision in this *policy*;
2. The date we receive a request from you to terminate this *policy*, or any later date stated in your request, or if you are enrolled through the Health Insurance Marketplace, the date of termination that the Health Insurance Marketplace provides us upon your request of cancellation to the Health Insurance Marketplace;
3. The date we decline to renew this *policy*, as stated in the Discontinuance provision;
4. The date of your death if this *policy* is an individual plan;
5. The date a *member's* eligibility for coverage under this *policy* ceases due to any of the reasons stated in the Eligibility and Enrollment section in this *policy*; or
6. The date a *member's* eligibility for coverage under this *policy* ceases as determined by the Health Insurance Marketplace.

Refund upon Cancellation

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

Reinstatement

We will reinstate a *policy* when it is erroneously terminated or cancelled. The reinstatement will result in restoration of the enrollment with no break in coverage.

If you enrolled through the Marketplace and your benefits were terminated because you did not pay your premium in full by the end of your grace period, you will not be able to reinstate your benefits.

If you did not enroll through the Marketplace and if any renewal premium is not paid within the time granted for payment, a subsequent acceptance of premium by us, which is not part of a new application, shall reinstate benefits under this *policy*. However, if we require an application for reinstatement and issue a conditional receipt for the premium tendered, benefits under the *policy* will be reinstated upon approval of the application by us. If we do not provide you with an approval or disapproval within 45 calendar days of issuing the conditional receipt, then the *policy* will be reinstated. The reinstated *policy* shall cover only *loss* resulting from accidental *injury* sustained after the date of reinstatement and *loss* due to *illness* that may begin ten calendar days after such date. In all other respects, you shall have the same rights as you had under the *policy* immediately before the due date of the defaulted premium, subject to any provisions endorsed or attached in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 calendar days prior to the date of reinstatement.

Discontinuance

90-Day Notice:

If we discontinue offering and decide not to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 90 calendar days prior to the date that we discontinue coverage. You will be offered an option to purchase any other coverage in the individual market we offer in your state at the time of discontinuance of this *policy*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180-Day Notice:

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

SUBROGATION AND RIGHT OF REIMBURSEMENT

As used herein, the term "*third-party*" means any party that is, 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 is paid as part of a settlement or judgment by any *third-party*.

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

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

By accepting benefits under this plan, the *member* specifically acknowledges Ambetter of Oklahoma's right to subrogation. When this plan provides health care benefits for expenses incurred due to *third-party* injuries, Ambetter of Oklahoma 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 of Oklahoma may proceed against any party with or without the *member's* consent.

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

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

1. To fully cooperate with us in order to obtain information about the *loss* and its cause;
2. To immediately inform us in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*;
3. To include the amount of benefits paid by us on behalf of a *member* in any claim made against any *third-party*;

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

No court costs or attorney fees may be deducted from the plan's recovery without the prior express written consent of the plan. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment is insufficient to make you whole. The plan expressly and unequivocally disavows the doctrines of common fund and made whole.

COORDINATION OF BENEFITS

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

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

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

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

1. If a plan is advised by a *member* that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's *deductible* is not an allowable expense, except for any health care expense incurred that may not be subject to the *deductible* as described in Section 223 (c)(2)(C) of the Internal Revenue Code of 1986.
2. An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.
3. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a *member* is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

1. If a person is confined in a private *hospital* room, the difference between the cost of a semi-private room in the *hospital* and the private room is not an allowable expense, unless one of the plans provides coverage for *hospital* room expenses.
2. If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.
3. If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated frees is not an allowable expense.

4. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement 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 benefits or services 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, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

The term "Plan" includes:

1. Group and non-group insurance contracts and *subscriber* contracts;
2. Uninsured arrangements of group or group-type coverage;
3. Group and non-group coverage through closed panel plans;
4. Group-type contracts;
5. The medical care components of long-term care contracts, such as skilled nursing care;
6. The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contract; and
7. Medicare or other governmental benefits, as permitted by law.

The term "Plan" does not include:

1. *Hospital* indemnity coverage benefits or other fixed indemnity coverage;
2. Accident only coverage;
3. Specified disease or specified accident coverage;
4. Limited benefit health coverage;
5. School accident-type coverages that cover students for accident only, including athletic injures, wither on a 24-hour basis or on a "to and from school" basis;
6. Benefits provided in long-term care insurance policies of non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, *respite care*, and *custodial care* or for contracts that pay a fixed daily benefits without regard to expense incurred or the receipt of services;
7. Medicare supplement polices;
8. A state plan under Medicaid; or
9. A governmental plan, which by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

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

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

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

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 1-7 that applies will determine which plan will be primary:

1. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. A plan may consider benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
2. If the other plan does not contain a coordination of benefits provision that is consistent with this provision, that plan is always primary. There are two exceptions:
    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987, which provides excess major medical benefits intended to supplement any basic benefits on a member may continue to be excess to such basic benefits.
3. Each plan determines its order of benefits using the first of the following rules that apply:
    a. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.
    b. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:
        i. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the calendar year (excluding year of birth) shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary.
        ii. If a child is covered by both parents' plans, the parents are separated or divorced, whether or not they have ever been married:
            A. If a court order or decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This rule applies to the plan years commencing after the plan is given notice of the court decree;
            B. If a court order or decree states that both parents are responsible for or orders joint custody without considering for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above shall determine the order of benefits.

C. If the parent with custody has remarried, and the child is also covered as a child under the stepparent's plan, the stepparent's plan will pay second, and the plan of the parent without custody will pay third;

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

a) The plan covering the custodial parent;

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

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

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

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

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

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

6. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

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

Effects of Coordination

When this plan is secondary, we may reduce benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, we will calculate the benefits we would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under this plan that is unpaid by the primary plan. We may then reduce our 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, we shall credit to our plan *deductible* any amounts we would have credited to the *deductible* in the absence of other health care coverage. Also, the amount we pay will not be more than the amount we would pay if we were

primary. When this plan is secondary as a result of one of our *members* being a Medicare beneficiary, see above definition for allowable expense, as we will reduce our benefits up to Medicare's allowable.

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

Right to Receive and Release Needed Information

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

Right of Recovery

If the amount of the payments made by this plan is more than we should have paid under this COB provision, we may recover the excess from one or more of the *members* we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the *member*. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services. If the *covered services* provided by us exceed the total amount of benefits that should have been paid under this section, we have the right to recover from one or more of the following claimant:

1. Any person to or from whom such payments were made;
2. *Member* was non eligible at the time of service; or
3. Insurance companies.

We have the right to recover from any claim six months after payment is made, and/or request a refund from a health care provider 12 months after payment is made.

CLAIMS

Notice of Claim

We must receive notice of claim within 30 calendar days of the date the *loss* began or as soon as reasonably possible. Notice given by or on behalf of the *member* or the beneficiary to the insurer at the following address or to any authorized agent of the insurer, with information sufficient to identify the *member*, shall be deemed notice to the insurer.

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

Proof of Loss

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

How to Submit a Claim

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

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

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

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

Claim Forms

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

Cooperation Provision

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

1. Sign, date and deliver to us *authorizations* to obtain any medical or other information, records or documents we deem relevant from any person or entity;

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

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

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

Time for Payment of Claims

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

Payment of Claims

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

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

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

Claims Incurred for Emergency Services While Traveling Outside the United States

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

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

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

Medicaid Reimbursement

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

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

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

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

Custodial Parent

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

Upon request by the custodial parent, we will:

1. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions, and limitations of the *policy*;
2. Accept claim forms and requests for claim payment from the custodial parent; and

3. Make claim payments directly to the custodial parent for claims submitted by the custodial parent. Payment of claims to the custodial parent, which are made under this provision, will fully discharge our obligations.

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

Physical Examination

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

Legal Actions

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

Change of Beneficiary

Unless you make an irrevocable designation of beneficiary, you have the right to change your beneficiary at any time and the consent of the beneficiary or beneficiaries shall not be required to surrender or assign this *policy* or to make any change of beneficiary or beneficiaries or to make any other changes in this *policy*.

APPEALS AND GRIEVANCES 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 procedures are available to address your concerns.

Call Member Services

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

Appeals

You, your *authorized representative*, or your provider (with your consent) have 180 calendar days to *appeal* an *adverse benefit determination*. An *adverse benefit determination* is issued when we deny, reduce or terminate, or fail to provide or make payment (in whole or in part) for, a benefit that you have already received (Post-Service), a result of *utilization review* (*prior authorization*), as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be *experimental* or *investigational* or not *medically necessary* or appropriate (Pre-Service); and any *rescission* of coverage.

Filing an Appeal

Appeals may be filed verbally by calling Member Services or in writing by completing the Grievance and Appeal Form from our website or sending a written *appeal* along with copies of any supporting documents. All *appeals* initiated verbally will need to be followed-up by a written and signed appeal request. Your appeal request with all supporting documents can be mail or fax to:

Ambetter of Oklahoma
Attn: Appeals and Grievances Department
P.O. Box 10341
Van Nuys, CA 91410
Fax: 1-833-886-7956
Telephone: 1-833-492-0679 (TTY: 711)

You, your *authorized representative*, or provider (with your consent) have the right to submit written comments, documents, records, and other information relevant to the appeal. You have the right to review the appeal file and to present evidence and testimony as part of the internal review process.

We will send you, your *authorized representative*, and your provider, if applicable, a written acknowledgment within five business days of receipt of your appeal. The notice will also let you know if any additional information is required in order for us to complete our review.

Appeals will be resolved within a reasonable period of time appropriate to the medical circumstances. We will notify you in writing with the appeal decision within the following timeframes:

1. Pre-Service *Appeals* (non-claim related): within 30 calendar days after receipt of the request for an internal appeal;
2. Post-Service *Appeals* (non-claim related): within 30 calendar days after receipt of the request for an internal appeal; or
3. Urgent or Expedited *Appeals*: within 72 hours after receipt of the request for an expedited pre-service appeal. (See Expedited Appeals for more details.)

If we are providing benefits for an ongoing course of treatment, they cannot be reduced or terminated without providing advance notice and an opportunity for advance review. We are required to provide continued coverage pending the outcome of an appeal.

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

1. You will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The plan will give a reasonable amount of time to respond to the new information before making a determination, without allowing such time to delay the contractual timeframe for resolution; or
2. You will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer. The plan will give a reasonable amount of time to respond to the new information before making a determination, without allowing such time to dela the contractual timeframe for resolution.

Expedited Appeals

Expedited *appeals* apply in situations when the plan determines or your provider indicates, when submitting an appeal on your behalf, that taking the time for a standard appeal resolution could seriously jeopardize your life, physical or mental health, or ability to attain, maintain, or regain maximum function. An expedited appeal may be submitted orally or in writing.

An expedited appeal shall be resolved as expeditiously as the claimant's health condition requires but not more than 72 hours after receipt of the *grievance*.

All necessary information, including our determination on review, will be transmitted to you, your *authorized representative*, or your provider, if applicable, by telephone, facsimile (fax), or other similarly expeditious available method.

Due to the 72-hour resolution timeframe, the standard requirements for notification and acknowledgement do not apply to expedited *appeals*.

Upon written request and free of charge we will provide reasonable access to, and copies of, all documents, records, and other information relevant to the appeal.

Written Appeal Response

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

Our written decision for an adverse determination appeal will include:

1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *grievance*;
3. The titles and qualifying credentials of the persons involved in making the decision;
4. A statement of the reviewer's understanding of the issues;
5. Reference to the evidence or documentation used as the basis for the decision;
6. Reference to the specific *policy* provision on which the determination is based on;

7. A statement that the *member* is entitled to receive, upon request and free of charge, reasonable access to and, copies of all documents, records, and other information relevant to the *member's* issue;
8. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the *member* upon request;
9. If the adverse determination is based on *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the *member's* medical circumstances or a statement that such explanation will be provided free of charge upon request;
10. A description of the procedures for obtaining an external review of the final adverse determination; and
11. If applicable:
    a. Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the adverse determination;
    b. The date of service;
    c. The health care provider's name;
    d. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
    e. A description of the external review procedures, if applicable;
    f. The right to bring a civil action under state or federal law;
    g. A copy of the form that authorizes Ambetter of Oklahoma to disclose protected health information, if applicable;
    h. That assistance is available by contacting the Oklahoma Department of Insurance, if applicable; and
    i. A culturally linguistic statement based upon the *member's* county or state of *residence* that provides for oral translation of the adverse determination, if applicable.

Grievances

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

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

Filing a Grievance

You or your *authorized representative* may file a *grievance* by calling Member Services or in writing by completing the Grievance and Appeal Form from our website or sending a letter to:

Ambetter of Oklahoma
Attn: Appeals and Grievances Department
P.O. Box 10341
Van Nuys, CA 91410
Telephone: 1-833-492-0679 (TTY: 711)

If filing a written *grievance*, please include:

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

We will acknowledge receipt of your *grievance* in writing within five business days. *Grievances* will be promptly investigated and will be resolved within 30 calendar days of receipt. The time period may be extended for an additional 14 calendar days.

Complaints Received from the State Insurance Department

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

External Review

An external review decision is binding on us. An external review decision is binding on the claimant except to the extent the claimant has other remedies available under applicable federal or state law. We will pay for the costs of the external review performed by the independent reviewer.

You may request an external review from:

Oklahoma Insurance Department
400 N. E. 50th Street
Oklahoma City, Oklahoma 73105
Telephone: 1-800- 522-0071 or 1-405-521-2828

After exhausting the internal review process, the claimant has four months to make a written request to the Insurance Commissioner for external review after the date of receipt of our internal response. You may request an external review by submitting an External Review Request Form that is available on the Oklahoma Insurance Department's website. Within one (1) business day after the date of receipt of a request for external review, the Insurance Commissioner will send a copy of the request to us.

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

External review is available for *grievances* that involve:

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

External Review Process

1. We have five business days (immediately for expedited external review requests) following receipt of the request to conduct a preliminary review of the request to determine whether:
    a. The individual was a *member* at the time the item or service was requested;
    b. The service is a *covered service* under the claimant's health plan but for the plan's *adverse benefit determination* with regard to *medical necessity experimental or investigational*, medical judgment, or *rescission*;
    c. The claimant has exhausted the internal process; and
    d. The claimant has provided all of the information required to process an external review.
2. Within one business day (immediately for expedited external review requests) after completion of the preliminary review, we will notify the Insurance Commissioner and the claimant in writing as to whether the request is:
    a. Complete and eligible for external review;

b. Complete but not eligible for external review and the reasons for its ineligibility; or

c. Not complete and the additional information needed to make the request complete;

3. Within one (1) business day of receiving notice that a request is eligible for external review (immediately for expedited external review requests), the Insurance Commissioner will assign an IRO;

4. Within five business days after the date of assignment of the IRO (or upon receipt of notice of the assignment of an IRO in the case of an expedited external review request), we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO;

   Note: For expedited, after assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method;

5. If we fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the *adverse benefit determination*;

6. Upon receipt of any information submitted by the claimant, the IRO must forward the information to us within one business day;

7. Upon receipt of the information, we may reconsider our determination. If we reverse our *adverse benefit determination*, we must provide written notice of the decision to the claimant and the IRO within one business day after making such decision. The external review would be considered terminated;

8. Within 45 calendar days (72 hours for expedited external reviews) after the date of receipt of the request for an external review by the health plan, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to the claimant and to us. If the notice for an expedited review is not in writing, the IRO must provide written confirmation within 48 hours after the date of providing the notice; and

9. Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, we will approve the *covered service* that was the subject of the *adverse benefit determination*.

Appeals and Grievances Filing and Key Communication Timelines

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard Grievance	N/A	5 business days	30 calendar days	14 calendar days
Standard Pre-Service Appeal	180 calendar days	5 business days	30 business days	N/A
Expedited Pre-Service Appeal	180 calendar days	N/A	72 hours	N/A
Standard Post-Service Appeal	180 calendar days	5 business days	30 business days	N/A
External Review	4 months	5 business days	45 calendar days	N/A
Expedited External Review	4 months	N/A	72 hours	N/A

GENERAL PROVISIONS

Entire Contract

This *policy*, the *Schedule of Benefits*, and the enrollment application, including any amendments or riders attached, is the entire contract between you and us. No change in this policy shall be valid until approved by an executive officer of Ambetter Health of Oklahoma and unless such approval is endorsed on or attached to this policy.

No agent may:

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

Non-Waiver

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

Time Limit on Certain Defenses

Relative to a misstatement in the application, after two years from the issue date, only fraudulent misstatements in the application may be used to void the *contract* or deny any claim for *loss* incurred or disability starting after the two-year period.

Repayment for Fraud, Misrepresentation or False Information

After two years from the date of issue of this *policy*, no misstatements, except fraudulent misstatements, made by the applicant in the enrollment application for such *policy* shall be used to void the *policy* or to deny a claim based upon such misstatement. During the first two years a *member* is covered under the *policy*, if a *member* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *policy* or in filing a claim for *policy* benefits, we have the right to demand that *member* pay back to us all benefits that we provided or paid during the time the *member* was covered under the *policy*.

Conformity with Applicable Laws

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

Personal Health Information (PHI)

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

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