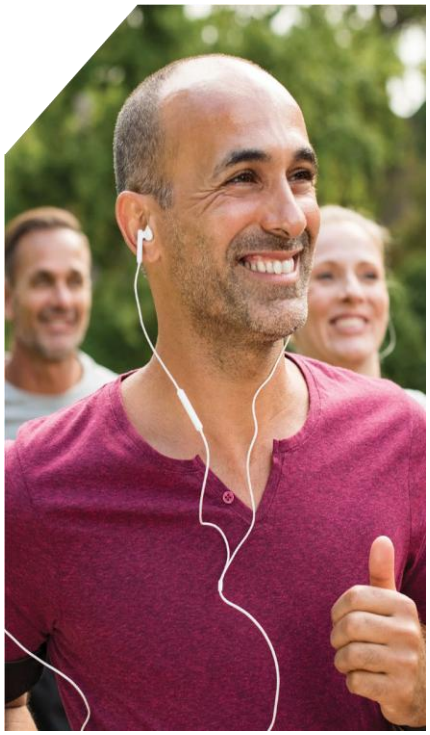
ambetter of Tennessee



2027 EVIDENCE OF COVERAGE

AMBETTER + ADULT VISION + ADULT DENTAL

AmbetterHealth.com/en/tn

70111TN012-2027

Ambetter of Tennessee

Issued and Underwritten by Celtic Insurance Company

Ambetter + Adult Vision + Adult Dental

Home Office: 1333 Burr Ridge Parkway, Suite 500, Burr Ridge, IL 60527

Individual Member Contract

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

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

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

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

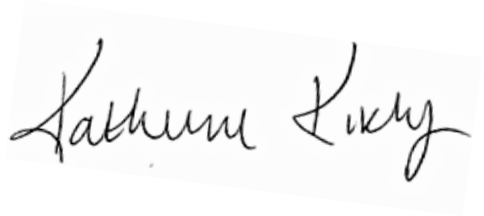
In addition to the above, this guarantee for continuity of coverage shall not prevent us from cancelling or non-renewing this *contract* in the following events: (1) non-payment of premium; (2) a *member* is found to be in material breach of this *contract*; or (3) a change in federal or state law, no longer permits the continued offering of such coverage, such as CMS guidance related to individuals who are Medicare eligible.

This *contract* contains *prior authorization* requirements.

Benefits may be reduced or not covered if the requirements are not met. Please refer to the *Schedule of Benefits* and the Utilization Management section.

RIGHT TO RETURN POLICY

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



Katherine W Kirby
President

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INTRODUCTION

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting you as a *member*.
2. Encouraging open discussions between you, your provider, and *medical practitioners*.
3. Providing information to help you become an informed health care consumer.
4. Providing access to *covered services* and our *network provider*s.
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 *PCP*, *specialist physician*, *hospital* or other *network provider* please contact us so we can assist you with accessing or locating a *network provider*. *Physicians* within our *network* may be affiliated with different *hospitals*. Our online directory can provide you with information for the *hospitals* that are contracted with us. The online directory also lists affiliations that your provider may have with non-contracted *hospitals*. Your Ambetter coverage requires you to use contracted providers with limited exceptions.

You have the right to:

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

8. Candidly discuss with your provider and *medical practitioners* appropriate and *medically necessary* care for your condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *PCP* about what might be wrong (to the level known), treatment and any known likely results. Your *PCP* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. You have a right to know about any costs you will need to pay. This should be told to you in words you can understand. When it is not appropriate to give you information for medical reasons, the information can be given to a legally *authorized representative*. Your provider will ask for your approval for treatment unless there is an emergency, and your life and health are in serious danger.
9. Voice *complaints* or *grievances* about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
10. See your medical records.
11. Be kept informed of covered and non-covered services, program changes, how to access services, *PCP* assignment, providers, advance directive information, referrals and *authorizations*, benefit denials, *member* rights and responsibilities, and our other rules and guidelines. We will notify you at least 60 calendar days before the *effective date* of the modifications. Such notices shall include:
    a. Any changes in clinical review criteria; or
    b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
12. A current list of *network provider*s.
13. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
14. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, ethnicity, race, religion, gender, sexual orientation, national origin, physical or mental disability, or expected health or genetic status.
15. Access *medically necessary* urgent and *emergency services* 24 hours a day and seven days a week.
16. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.
17. Refuse treatment to the extent the law allows. without jeopardizing future treatment and be informed by your provider(s) of the medical consequences. You are responsible for your actions if treatment is refused or if the *PCP's* instructions are not followed. You should discuss all concerns about treatment with your *PCP*. Your *PCP* can discuss different treatment plans with you, if there is more than one plan that may help you. You will make the final decision.
18. Select your *PCP* within the *network*. You also have the right to change your *PCP* or request information on *network provider*s close to your home or work.
19. Know the name and job title of people giving you care. You also have the right to know which provider is your *PCP*.

20. An interpreter when you do not speak or understand the language of the area.
21. A second opinion by a *network physician* if you want more information about your treatment or would like to explore additional treatment options.
22. Make advance directives for health care decisions. This includes planning treatment before you need it.
23. Determine what actions should be taken regarding your health if you are no longer able to make decisions for yourself because of *illness* or because you are incapacitated. You have the right to have your wishes known by completing advance directives forms. Advance directive forms are forms you can complete to protect your rights for medical care. It can help your *PCP* and other providers understand your wishes about your health. Advance directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself. Examples of advance directives include:
    a. Living Will;
    b. Health Care Power of Attorney; or
    c. “Do Not Resuscitate” orders. *Members* also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this entire *contract*.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about your health that we or your *medical practitioners* need to provide care. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your provider until you understand the care you are receiving.
4. Review and understand the information you receive about us. You need to know the proper use of *covered services*.
5. Show your *member* identification card and keep scheduled appointments with your provider and call the provider’s office during office hours whenever possible if you have a delay or cancellation.
6. Know the name of your assigned *PCP*. You should establish a relationship with your provider. You may change your *PCP* verbally or in writing by contacting Member Services.
7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
8. Supply, to the extent possible, information that we or your health care professionals and providers need in order to provide care.
9. Follow the treatment plans and instructions for care that you have agreed on with your health care professionals and provider.

10. Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you. You should work with your *PCP* to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.
11. Follow all health benefit plan guidelines, provisions, policies, and procedures.
12. Use any emergency room only when you think you have a medical emergency. For all other care, you should call your *PCP*.
13. When you enroll in this coverage, give all information about any other medical coverage you have. If, at any time, you get other medical coverage besides this coverage, you must tell the entity with which you enrolled.
14. Pay your monthly premiums on time and pay all *deductible amounts*, *copayment amounts*, or *coinsurance amounts* at the time of service.
15. Notify us 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 provider*s is available online at AmbetterHealth.com/en/tn. We have plan providers, *hospitals*, and other *medical practitioners* who have agreed to provide you with your health care services. You may find any of our *network provider*s by accessing the "Find a Doctor" page on our website and selecting the Ambetter *network*. There you will have the ability to narrow your search by provider specialty, zip code, gender, languages spoken and whether or not they are currently accepting new patients. Your search will produce a list of providers based on your search criteria and will give you other information such as name, address, phone number, office hours, and specialty and board certifications.

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

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

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

If you receive services from a *non-network provider* because of inaccurate information in the provider directory or in response to an inquiry about *network* status, please contact 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 provider*s and will not be *balance billed* by the *non-network provider*.

Member Identification Card

We will mail you a *member* identification card after our receipt of your completed enrollment materials and you had paid your initial premium payment. This card is proof that you are enrolled in the Ambetter plan. You need to keep this card with you at all times. Please show this card every time you go for any service under the *contract*.

The *member* identification card will show your name, *member* identification number, and *copayment amounts* required at the time of service. Any applicable *deductibles*, and any applicable out-of-pocket maximum amounts 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 and 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/tn. 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 amounts* accumulators.
9. Selecting a *primary care physician*.

If you have material modifications (examples include a change in life event such as marriage, death, or other change in family status), or questions related to your health insurance coverage, contact the Health Insurance Marketplace at www.healthcare.gov, or 1-800-318-2596. If you enrolled through Ambetter, contact Member Services, or you can access your Ambetter Online Member Account to process these changes. You can access your consumer dashboard at enroll.ambetterhealth.com to process these changes.

Quality Improvement

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

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

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

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

Protection from Balance Billing

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

Right to Shop

In order to accommodate Tennessee's requirements for the Right to Shop Act, Ambetter has created and put in place a program to field incoming calls for information. *Members* seeking price estimates for procedures and services can call Member Services to inquire about pricing. Member Services agents at Ambetter are able to provide *members* with cost estimates utilizing two different systems:

1. HealthSparq: Provides a good faith estimate of costs for non-emergency procedures/services.
2. Member Portal: Provides *members cost share* information, including current totals of expenses paid to date.

DEFINITIONS

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

Wherever used in this *contract*:

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

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

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

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

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

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

Allowed amount (also see *Eligible expense*) means the maximum amount we will pay a provider for a *covered service*. When a *covered service* is received from a *network provider*, the *allowed amount* is the amount the provider agreed to accept from us as payment for that particular service. In all cases, the *allowed amount* will be subject to *cost sharing* (e.g., *deductible*, *coinsurance* and *copayment amounts*) per the *member's* benefits. A *non-network provider* must give you a detailed breakdown of the estimated amount you will pay out of pocket for the non-*network* services, for you or your personal representative to sign (Tenn. Code Ann. 68-11-243). Be sure to always check whether a provider you are referred to is in our *network*. This amount excludes agreed to amounts between the provider and us as a result of federal or state arbitration.

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

Ambetter-designated telehealth provider means the vendor selected by Ambetter to *contract* with providers to render *telehealth services*, including *Virtual 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 for Ambetter to reconsider a previous decision including an *adverse benefit determination* or *final adverse benefit determination*.

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

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

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

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

1. A person to whom a *member* has given express, written consent to represent that individual in an internal *appeals* process or external review process of an *adverse benefit determination*;
2. A person authorized by law to provide substituted consent for a *member*;
3. A family member or a treating health care professional, but only when the *member* is unable to provide consent;
4. A health care professional when the *member's* health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or
5. In the case of an urgent care request, a health care professional with knowledge of the *member's* medical condition.

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

Balance billing means a *non-network provider* billing you for the difference between the provider's charge for a service and the *eligible expense*. *Network provider*s may not balance bill you for *covered services* beyond your applicable *cost sharing* amounts. See the *Allowed Amount* definition for more detail.

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

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

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

Behavioral health means both *mental health disorder* and *substance use disorder*, 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 *contract* and ending December 31st of that year. For each following year it is the period from January 1st through December 31st.

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

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*.

Claimant means a *member*, a *member's authorized representative*, or provider acting on the *member's* behalf who files a *grievance* or *appeal*.

Coinsurance amount or ***coinsurance*** means the percentage of *covered services* that you are required to pay when you receive a 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, preeclampsia, and similar medical and surgical conditions of comparable severity.

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

Continuing care patient means an individual who, with respect to a provider or facility, is (i) undergoing a treatment for a *serious and complex condition* from that provider or facility; (ii) is undergoing a course of institutional or *inpatient* care from that provider or facility; (iii) is scheduled to undergo non-elective *surgery* from that provider, including postoperative care; (iv)

is pregnant and undergoing a course of treatment for the *pregnancy*; or (v) is or was determined to be *terminally ill* and is receiving treatment for such *illness*.

Contract means this *contract* issued and delivered to you. It includes the attached pages, the applications, and any amendments.

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*. 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 provider*s, *cost-sharing* may be based on an amount different from the *allowed amount*.

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

Cost share or ***cost sharing*** means the *deductible amount*, *copayment amount*, and *coinsurance* that you pay for *covered services*. The *cost sharing* amount that you are required to pay for each type of *covered service* is listed in the *Schedule of Benefits*.

Cost sharing reductions mean the reduction of 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 Health Insurance Marketplace. *Members* of a federally recognized American Indian tribe and/or an Alaska Native may qualify for additional *cost sharing reductions*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Emergency condition means a medical condition or a *behavioral health* condition manifesting itself by acute symptoms of sufficient severity (including severe pain) regardless of the final diagnosis 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 means *covered services* needed to evaluate and *stabilize* an *emergency condition*. This includes a medical screening examination in a *hospital* emergency department (including labor and delivery departments) or independent freestanding emergency department to evaluate the *emergency condition*, as well as services needed to *stabilize* the *emergency condition*. Services to *stabilize* an *emergency condition* can be provided in any department of a *hospital*.

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

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

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

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

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

services, or institutions that primarily provide for the care and treatment of *behavioral health* or pulmonary tuberculosis.

External appeal means a request for an independent, external review of the *final adverse benefit determination* made by the Plan through its internal *appeal* process. This may include, but is not limited to, Independent Review Entity or Quality Improvement Organization.

Final adverse benefit determination means an *adverse benefit determination* involving a *covered service* that has been upheld by a health carrier at the completion of the health carrier's internal *grievance* process procedures.

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

If no credible scientific evidence is available, then standards based on provider specialty society recommendations or professional standards of care may be considered. We reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered service* under the *contract*. The decision to apply provider 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 an expression of dissatisfaction about any matter other than an *adverse benefit determination*. *Grievances* may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the *member's* rights regardless of whether remedial action is requested. *Grievances* includes a *member's* right to dispute an extension of time proposed by the plan to make an *authorization* decision.

Habilitation or habilitation services /therapy 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 provider.

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 provider, in accordance with existing *generally accepted standards of medical practice* for the *injury* or *illness* requiring the *home health care*.
5. 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 persons as *inpatients*;
3. Provides 24-hour nursing service by registered nurses on duty or call;
4. Has staff of one or more providers available at all times;
5. Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical, or *mental health disorder* conditions either on its premises or in facilities available to it on a prearranged basis; and
6. Is not primarily a long-term care facility; an *extended care facility*, nursing, rest, *custodial care*, or convalescent home; a halfway house, transitional facility, or *residential treatment facility*; a facility for wilderness or outdoor programs; or a similar establishment.

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

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

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

Independent review organization (IRO) means an entity that conducts independent external reviews of *adverse benefit determinations* and *final adverse benefit determination*s of a health carrier (also known as an External Review Organization (ERO).

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

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

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

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

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

Maximum out-of-pocket amount means the maximum amount a *member* must pay towards *covered services* in the form of *cost sharing* in a given plan year. A *member's deductible amount*, *prescription drug deductible amount* (if applicable), *copayment amounts*, and *coinsurance amounts* all contribute towards the *maximum out-of-pocket amount*. The individual and family *maximum out-of-pocket amount*s 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 provider, nurse anesthetist, *physician's* assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *contract*: rolfer, marriage counselor, naturopath, massage therapist or sociologist. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to *generally accepted standards of medical practice*;
3. Is not *custodial care*;
4. Is not solely for the convenience of the 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 that is not *medically necessary* are not *eligible expenses*.

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

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

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

Necessary medical supplies mean medical supplies that are:

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

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

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

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

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

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

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

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

3. Air ambulance services; and
4. Situations otherwise specifically described in this *contract*.

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

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

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

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

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

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

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

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

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

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

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

Pre-service appeal means a request to change an *adverse benefit determination* for care or service that the Plan must approve, in whole or in part, in advance of the *member* obtaining care or services.

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

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

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

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

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

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

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

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

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

Qualified health plan or ***QHP*** means a health plan that has in effect a certification that it meets the standards described in 45 CFR Subpart C, Part 156 issued or recognized by each Health Insurance Marketplace through which such plan is offered in accordance with the process described in 45 CFR Subpart K, Part 155.

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

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

Rehabilitation or ***rehabilitation services*** 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* or treatment.

Rehabilitation facility means an institution or a separate identifiable *hospital* unit, section, or ward that is licensed by the state as a *rehabilitation facility*. It operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured *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 provider, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation licensed practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

Rescission means a determination by an insurer to withdraw the coverage back to the date of the act that prompts the *rescission*.

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 or ***residential treatment center (RTC)*** 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*. *RTCs* do not provide acute care. They are generally used as a step-down from more intensive/acute care settings. **NOTE:** The duration of stay covered under this *contract* for an *RTC* 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 mean *prescription drugs* that are delivered into a muscle or under the skin with a syringe and needle. Although medical supervision or instruction may be needed in the beginning, the patient or caregiver can administer *self-injectable drugs* safely and effectively.

Serious and complex condition means, in the case of an acute *illness*, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or, in the case of a chronic *illness* or condition, a condition that is

life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

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

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

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

Specialist physician means a *physician* or *medical practitioner* who focuses on a specific area of medicine and has additional expertise to help treat specific disorders or *illnesses*. 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 Service Benefits provision under the Major Medical Expense Benefit section).

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

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

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

Surrogacy/gestational carrier arrangement means an understanding in which a woman (the *surrogate*/gestational carrier) 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*/gestational carrier receives payment for acting as a *surrogate*/gestational carrier.

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

Telehealth services 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* include synchronous interactions and asynchronous store and forward transfers.

Terminally ill means a provider 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 *contract* under which the *member* is entitled to benefits as a named insured person or an insured *dependent member* of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit our right to recover from these sources.

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

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

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

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

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

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

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

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

DEPENDENT MEMBER COVERAGE

Dependent Member Eligibility

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

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

Effective Date for Initial Dependent Members

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

Coverage for a Newborn Child

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

Additional premium will be required to continue coverage beyond the 31st calendar day after the date of birth. The required premium will be calculated from the child's date of birth. If notice of the newborn is given to us by the Health Insurance Marketplace within the 31 calendar days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 calendar days after the birth of the child. If notice is not given 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 birth unless we have received notice by the Health Insurance Marketplace of the child's birth.

Coverage for an Adopted Child

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

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

Additional premium will be required to continue coverage beyond the 31st calendar day following placement of the child and we have received notification from the Health Insurance

Marketplace. Coverage of the child will terminate on the 31st calendar day following placement unless we have received both: (a) Notification of the addition of the child from the Health Insurance Marketplace within 60 calendar days of the birth or placement and (b) any additional premium required for the addition of the child within 90 calendar days of the date of placement.

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 member*.

ELIGIBILITY AND ENROLLMENT

For All Members

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

1. The *subscriber* resides outside of the *service area* or moves permanently outside the *service area* of this plan;
2. The date of termination that the Health Insurance Marketplace provides to us upon your request of cancellation to the Health Insurance Marketplace, or if you enrolled directly with us, the date we receive a request from you to terminate this *contract*, or any later date stated in your request;
3. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *contract* or the date that we have not received timely premium payments in accordance with the terms of this *contract*;
4. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact;
5. The date of a *member's* death;
6. The date we decline to renew this *contract*, as stated in the Discontinuance provision; or

If you have material modifications (examples include a change in life event (marriage, death) or family status), or questions related to your health insurance coverage, contact the Health Insurance Marketplace at www.healthcare.gov or 1-800-318-2596. If you enrolled through Ambetter, contact Member Services.

For Dependent Members

A *dependent member* will cease to be a *member* at the end of the premium period in which he or she ceases to be your *dependent member* due to divorce or if a child ceases to be an *eligible child*. For *eligible children*, the coverage will terminate at 11:59 p.m. on the last day of the year in which dependent child reaches the limiting age of 26.

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

1. Incapable of self-sustaining employment by reason of intellectual or physical disability; and
2. Chiefly dependent upon you for support and maintenance, provided proof of the incapacity and dependency is furnished to us within thirty-one (31) calendar days of the dependent *eligible child* attainment of the limiting age and subsequently as may be required by us, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

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 November 1st of the current year, and extends through January 15th of the following year. Coverage for q*ualified individuals* who enroll on or before December 15th, will have an *effective date* of coverage on January 1st of the following year.

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

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 experiences a loss of *minimum essential coverage*, non-calendar year group or individual health insurance coverage, pregnancy-related coverage, access to health care services through coverage provided to a pregnant *member's* unborn child, or medically needed coverage.
2. A *qualified individual* gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order.

   In the case of marriage, at least one *spouse* must demonstrate having *minimum essential coverage* as described in 26 CFR 1.5000A-1(b) for 1 or more calendar days during the 60 calendar days preceding the date of marriage.
3. A *qualified individual* or dependent, who was not previously a citizen, national, or lawfully present individual gains such status; or who is no longer incarcerated or whose incarceration is pending the disposition of charges.
4. A *qualified individual's* enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or its instrumentalities as evaluated and are determined by the Health Insurance Marketplace.
5. A *member* or dependent adequately demonstrates to the Health Insurance Marketplace that the plan in which he or she is enrolled substantially violated a material provision of its *contract* in relation to the *member*.
6. A *qualified individual*, *member*, or dependent, adequately demonstrates to the Health Insurance Marketplace that a material error related to plan benefits, *service area*, or premium influenced the *qualified individual's* or *member's* decision to purchase the *QHP*.
7. A *member* or dependent 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 *advanced 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 may be provided.
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.

18. At the option of the Exchange, the *qualified individual*, or his or her dependent:
    a. Experiences a decrease in household income;
    b. Is newly determined eligible by the Exchange for advance payments of the premium tax credit; and
    c. Had *minimum essential coverage* as described in 26 CFR 1.5000A-1(b) for one or more days during the 60 calendar days preceding the date of the financial change.

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

If you are currently enrolled in Ambetter of Tennessee, please contact Member Services with any questions related to your health insurance coverage.

Coverage Effective Dates for Special Enrollment Periods

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

Special effective dates. In the case of birth, adoption, placement for adoption, or placement in foster care, coverage is effective for a *qualified individual* or *member* on the date of birth, adoption, placement for adoption, or placement in foster care. In the case of marriage, or in the case where a *qualified individual* experiences a loss of *minimum essential coverage*, coverage is effective on the first 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 Individual Coverage Health Reimbursement Arrangement (ICHRA) or is newly provided a Qualified Small Employer Health Reimbursement Account (QSEHRA), and if the plan selection is made before the day of the triggering event, coverage is effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the

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

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

Prior Coverage

If a *member* is confined as an *inpatient* in a *hospital* on the *effective date* of this agreement, and prior coverage terminating immediately before the *effective date* of this agreement furnishes benefits for the hospitalization after the termination of prior coverage, then services and benefits will not be covered under this agreement for that *member* until the *member* is discharged from the *hospital* or benefits under the prior coverage are exhausted, whichever is earlier. “Discharge” means a formal release of an *member* from an *inpatient hospital* stay when the need for continued care at an *inpatient hospital* has concluded. Transfers from one *inpatient hospital* to another shall not be considered a discharge.

If there is no prior coverage or no continuation of *inpatient* coverage after the *effective date*, your Ambetter coverage will apply for covered benefits related to the *inpatient* coverage after your *effective date*. Ambetter coverage requires you notify Ambetter within 2 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:

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

We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. We will notify 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 on or before the first day of each month for coverage effective during such month. There is a 60-calendar day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *contract* will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. We will notify Health and Human Services (HHS), as necessary, of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the grace period.

Third-Party Payment of Premiums or Cost Sharing

Ambetter requires each *contract* holder to pay his or her premiums and this is communicated on your monthly billing statements. Ambetter 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 Ambetter 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. Family members;
5. An employer for an employee under an ICHRA or QSEHRA plan; or
6. Private, not-for-profit foundations which have no incentive for financial gain, no financial relationship, or affiliation with providers of *covered services* and supplies on behalf of *members*, where eligibility is determined based on defined criteria without regard to health status and where payments are made in advance for a coverage period from the *effective date* of eligibility through the remainder of the *calendar year*.

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

Misstatement of Age

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

Change or Misstatement of Residence

If you change your *residence*, you must notify the Health Insurance Marketplace of your new *residence* within 60 calendar days of the change. As a result, your premium may change, and you may be eligible for a special enrollment period. See the Special Enrollment Periods provision in the Eligibility and Enrollment section for more information.

Misstatement of Tobacco or Nicotine Use

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

UTILIZATION MANAGEMENT

Authorization Requirements

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

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

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

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

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

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

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

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

1. For urgent concurrent reviews received at least 24 hours prior to the expiration of a previously approved course of treatment, within 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, within 2 business days from date of receipt of request.
3. For non-urgent pre-service requests, within 2 business days of receipt of the request.
4. For post-service requests, within 30 calendar days of receipt of the request.
5. For standard pharmacy requests, within 15 calendar days of receipt of request and urgent pharmacy requests, within 72 hours or two business days of receipt of request (whichever is lesser).

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

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

How to Obtain Prior Authorization

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

Failure to Obtain Prior Authorization

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

*Network provider*s 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 *contract*.

Requests for Predeterminations

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

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

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

Services from Non-Network Providers

Except when *balance billing protections* apply to a *covered service* provided by a *non-network provider*, we do not normally cover services received from *non-network provider*s. If a situation

arises where a *covered service* cannot be obtained from a *network provider* located within a reasonable distance, we may provide *prior authorization* for you to obtain services from a *non-network provider* at no greater cost to you than if you went to a *network provider*. If *covered services* are not available from a *network provider*, you or your *PCP* must request *prior authorization* from us before you may receive services from a *non-network provider*. If required *medically necessary* services are not available from *network provider*s, you or the *network provider* must request *prior authorization* from us before you may receive services from *non-network provider*s. Otherwise, you will be responsible for all charges incurred.

Authorization Denials

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

COST SHARING FEATURES

Cost Sharing Features

We will pay benefits for *covered services* as described in the *Schedule of Benefits* and the Major Medical Expense Benefits sections of this *contract*. All benefits we pay will be subject to all conditions, limitations, and *cost sharing* features of this *contract*. *Cost sharing* means that you participate or share in the cost of your health care services by paying *deductible amounts*, *copayments* and *coinsurance* for some *covered services*. For example, you may need to pay a provider a *deductible*, *copayment amounts* or *coinsurance amount* when you visit your provider or are admitted into the *hospital*. The *copayment amounts* 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 *contract* are adjudicated or processed as we receive them. Coverage is only provided for *eligible expenses*. Each claim received will be processed separately according to the *cost share* as outlined in the *contract* and in your *Schedule of Benefits*.

Deductible

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

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

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

Copayments

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

Coinsurance Percentage

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

service or supply. *Coinsurance amounts* do not apply toward the *deductible* but do apply toward your *maximum out-of-pocket amount*. When the annual maximum out-of-pocket has been met, additional *covered services* will be provided at 100 percent.

Refer to your *Schedule of Benefits* for *coinsurance* percentage and other limitations.

The amount provided or payable will be subject to:

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

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

Non-Network Liability and Balance Billing

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

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

Maximum Out-of-Pocket

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

When the annual *maximum out-of-pocket amount* has been met, additional *covered services* will be provided or payable at 100% of the allowable expense.

The amount provided or payable will be subject to:

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

ACCESS TO CARE

Primary Care Physician (PCP)

In order to obtain benefits, you must designate a *primary care physician* for each *member*. If you do not select a *network PCP* for each *member*, one will be assigned. You may select any *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 provider*s. See your *Schedule of Benefits* for more information.

Adults may designate an OB/GYN as a *primary care physician*. You may obtain a list of *primary care physician*s at our website and accessing the "Find a Doctor" page or by contacting Member Services.

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

1. Provide preventive care and screenings.
2. Conduct regular physical examinations as needed.
3. Conduct regular immunizations as needed.
4. Deliver timely service.
5. Work with other doctors when you receive care somewhere else.
6. Coordinate specialty care with Ambetter *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 directive are and file directives appropriately in your medical record.

Changing Your Primary Care Physician (PCP)

You may change your *primary care physician* for any reason, but not more frequently than once a month, by submitting a written request online at our website, AmbetterHealth.com/en/tn, or by contacting us at the number shown on your *member* identification card. The change to your *primary care physician* 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 you bring your *member* identification card and a photo identification.

Should you need care outside of your *PCP's* office hours, you should call your *PCP's* office for information on receiving after hours care in your area. If you have an urgent medical problem or question or cannot reach your *PCP* during normal office hours, call our 24/7 nurse advice line at 1-833-709-4735 (Relay 711). A licensed nurse is always available and ready to answer your health questions. If you are experiencing an *emergency condition*, call 911 or for a *behavioral health emergency condition*, call 988 or go to the nearest emergency room.

Non-Emergency Services

If you are traveling outside of the Ambetter of Tennessee *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 Tennessee by searching the relevant state and the plan you are enrolled in on our provider directory at guide.ambetterhealth.com. Not all states have Ambetter plans. If you receive care from an Ambetter provider outside of the *service area*, you may be required to receive *prior authorization* for non-emergency services. Contact Member Services at the phone number on your *member* identification card for further information.

Emergency Services Outside of Service Area

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

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

New Technology

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

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

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

Preferred Partnership

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

Network Availability

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

Coverage under Other Policy Provisions

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

Hospital Based Providers

When receiving care at a *network hospital* it is possible that some hospital-based providers may not be *network provider*s. If you provide *notice and consent* to waive *balance billing protections*, you may be responsible for payment of all or part of the balance bill. Any amount

you are obligated to pay to the *non-network provider* in excess of the *eligible expense* will not apply to your *deductible amount* or *maximum out-of-pocket amount*.

You may not be *balance billed* for non-emergency 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), received from a *non-network provider* at a *network hospital* or *network ambulatory surgical center*.

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 the *member* who is a *continuing care patient* on a timely basis of the termination and their right to elect continued transitional care from the provider;
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 to have their benefits for the course of treatment relating to their status as a *continuing care patient* during the period beginning on the date on which the notice described in (1) is provided and ending on the earlier of:
    a. 120 calendar days after the notice described in (1) is provided; or
    b. The date on which such *member* is no longer a *continuing care patient* with respect to the provider.

MAJOR MEDICAL EXPENSE BENEFITS

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

Acquired Brain Injury Services

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

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

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

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

Ambulance Service Benefits

Air Ambulance Service Benefits

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

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

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

Limitations:

Benefits for air ambulance services are limited to:

1. Services requested by police or medical authorities at the site of an *emergency 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 and paid 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.
   c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States.
4. Air ambulance services provided for a *member's* comfort or convenience.
5. Non-emergency air transportation (for example, commercial flights).

Ground and Water Ambulance Service Benefits

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

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

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

Note: Unless otherwise required by federal or Tennessee law, if you receive services from non-*network* ambulance providers, you may be *balance billed*.

Exclusions:

No benefits will be paid for:

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

Autism Spectrum Disorder Benefits

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

1. Evaluation and assessment services;
2. *Applied behavior analysis (ABA)* therapy;
3. Behavior training and behavior management;
4. *Habilitation services;*
5. Speech therapy;
6. Occupational therapy;
7. Physical therapy;

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

No limitation exists within the benefits for *applied behavior analysis* services. These services are subject to *prior authorization* to determine medical necessity. If multiple services are provided on the same day by different providers, a separate *copayment amounts* and/or *coinsurance* will apply to each provider.

Benefit Limitations

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

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 *primary care physician (PCP)* and other providers to develop a care plan that meets your needs and your caregiver's needs.

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

Chiropractic Services

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

Clinical Trial Coverage

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

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

3. All items and services that are otherwise generally available to a *qualified individual* that are provided in the clinical trial except:
    a. The *investigational* item or service itself;
    b. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
    c. Items and services customarily provided by the research sponsors free of charge for any *member* in the trial.

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

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

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

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

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

Providers participating in clinical trials shall obtain a patient's informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.

Participation in clinical trials is subject to *prior authorization* requirements as outlined in this *contract*.

Dental Benefits – Adults 19 years of age or older

Coverage for *dental services* is provided for adults, age 19 or 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;
   b. Endodontics – root canals;
   c. Periodontics – scaling and root planing and periodontal maintenance;
   d. Removeable 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 use disorder* counseling;
14. Services for teeth retained in relation to an overdenture;
15. Any oral *surgery* that includes surgical endodontics (apicoectomy and retrograde filling);
16. Analgesia (nitrous oxide);
17. Temporary procedures;
18. Splinting;
19. Temporomandibular joint (TMJ) disorder appliances, therapy, films and arthrograms;
20. Oral pathology laboratory charges;
21. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
22. Veneers (bonding of coverings to the teeth);
23. Orthodontic treatment procedures;
24. Orthognathic *surgery*;
25. Athletic mouth guards;
26. Space maintainers.

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

Covered services include, but are not limited to:

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

7. Educational health and nutritional counseling for self-management, eye examinations, prescription medication; and retinopathy examination screenings, as *medically necessary*.

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

Dialysis Services

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

Covered services include:

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

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

Disposable Medical Supplies

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

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

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

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

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

Benefits for repairs and replacement do not include the following:

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

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

Durable Medical Equipment (DME)

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

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

1. Hemodialysis equipment.

2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. 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. For one pair of foot orthotics per year per *member*.
10. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
11. For the rental of one Continuous Passive Motion (CPM) machine per *member* following a covered joint *surgery*.
12. *Medically necessary* corrective footwear; *prior authorization* may be required.

Exclusions:

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

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

All types of *durable medical equipment* and supplies are subject to *prior authorization* as outlined by this *contract*. Please see your *Schedule of Benefits* for benefit levels or additional limits.

Medical and Surgical Supplies

Covered services include coverage for non-durable medical supplies and equipment for management of disease and treatment of medical and surgical conditions.

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

1. Allergy serum extracts.
2. Chem strips, glucometer, lancets.
3. Clinitest.

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

Exclusions:

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

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

Orthotic Devices

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

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

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

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

Exclusions:

Non-covered services and supplies include, but are not limited to, garter belts, and other supplies not specifically made and fitted (except as specified under the Medical Supplies provision).

Prosthetics

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

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

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

Covered services may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per benefit period, as required by the Women's Health and Cancer Rights Act. Maximums for *prosthetic devices*, if any, do not apply.
4. Replacements for artificial eyes or larynx, breast prosthesis, or basic artificial limbs, including *medically necessary* repairs or replacement to restore or maintain a *member's* ability to perform activities of daily living or essential job-related activities.
5. One hearing aid per ear, every three years.
6. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are *covered services*. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract *surgery* or *injury*; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of *surgery* are not considered contact lenses and are not considered the first lens following *surgery*. If the *injury* is to one eye or if cataracts are removed from only one eye and the *member* selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.

7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (not to exceed one per benefit period) when purchased through a *network provider*.
10. Cochlear implant and bone anchored hearing aids

Exclusions:

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

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

Emergency Services

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

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

Essential Health Benefits

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

Coverage is limited to essential health benefits and other benefits as required under *applicable laws*. Services that are not essential health benefits, and are not otherwise required to be covered under *applicable laws*, are not covered under this *contract*.

Family Planning and Contraception

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

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

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

Fertility Preservation

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

Habilitation, Rehabilitation, and Extended Care Facility Expense Benefits

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

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

Cardiac *rehabilitation* is a *covered service*. However, cardiac *rehabilitation* services provided on a non-monitored basis and treatment for intellectual disability are excluded.

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

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

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

Home Health Care Service Expense Benefits

Covered services and supplies for *home health care* are 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. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care*.
3. Intravenous medication and pain medication.
4. Skilled services of a registered nurse or licensed practical nurse rendered on an *outpatient* basis.
5. Hemodialysis, and for the processing and administration of blood or blood components.
6. *Necessary medical supplies*.
7. Rental or purchase of *medically necessary durable medical equipment* at the discretion of the plan. 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.

Charges under (3) are *covered services* to the extent they would have been *covered services* during an *inpatient hospital* stay.

Limitations:

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

Exclusions:

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

Home health care services and benefits are subject to *prior authorization* requirements as outlined in this *contract*.

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 home setting. *Covered services* and supplies include:

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

Exclusions and Limitations:

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

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

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

Respite care is covered on an *inpatient* or home basis to allow temporary relief to family *members* from the duties of caring for a *member* under *hospice* care. Respite days that are applied toward the *members cost share* obligations amount are considered benefits provided and shall apply against any maximum benefit limit for these services.

Hospital Benefits

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

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

Infertility Services

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

Long Term Acute Care Hospital

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

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

1. Complex wound care:
    a. Daily *physician* monitoring of wound;
    b. Wound requiring frequent complicated dressing changes, and possible repeated debridement of necrotic tissue;
    c. Large wound with possible delayed closure, draining, and/or tunneling or high output fistulas;
    d. Lower extremity wound with severe ischemia;
    e. Skin flaps and grafts requiring frequent monitoring.
2. Infectious disease:
    a. Parenteral anti-infective agent(s) with adjustments in dose;
    b. Intensive sepsis management;
    c. Common conditions include osteomyelitis, cellulitis, bacteremia, endocarditis, peritonitis, meningitis/encephalitis, abscess, and wound infections;
3. Medical complexity:
    a. Primary condition and at least two other actively treated co-morbid conditions that require monitoring and treatment;
    b. Common conditions include metabolic disorders, stroke, heart failure, renal insufficiency, necrotizing pancreatitis, emphysema (COPD), peripheral vascular disease, and malignant/end-stage disease;
4. *Rehabilitation*:
    a. Care needs cannot be met in a *rehabilitation* or *skilled nursing facility*;
    b. Patient has a comorbidity requiring acute care;
    c. Patient is able to participate in a goal-oriented *rehabilitation* plan of care;
    d. Common conditions include CNS conditions with functional limitations, debilitation, amputation, cardiac disease, orthopedic *surgery*;
5. Mechanical ventilator support:
    a. Failed weaning attempts at an acute care facility;
    b. Patient has received mechanical ventilation for 21 consecutive days for six hours or more per day;
    c. Ventilator management required at least every four hours as well as appropriate diagnostic services and assessments;
    d. Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions;
    e. Patient is hemodynamically stable and not dependent on vasopressors;

f. Respiratory status is stable with maximum PEEP requirement 10 cm H2O, and FiO2 60% 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 Benefit

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

Mammography

Covered services for a *member* shall include mammography screenings in accordance with USPSTF A and B rated guidelines. In accordance with *applicable law*, no *cost share* will be applied to diagnostic/supplemental examinations for breast cancer, including breast magnetic resonance imaging, mammograms and ultrasounds and pathology evaluations. Coverage is available to all *members*, regardless of age, when these services are prescribed by a licensed healthcare provider within their professional scope. For further details on this benefit, please refer to the Preventive Care Guide. **Note**: For HSA-compatible plans, the *deductible* cannot be waived for benefits that exceed the federal ACA preventive care requirements.

Maternity Care

An *inpatient* stay is covered for mother and newborn for a minimum of 48 hours following a vaginal delivery and 96 hours following a delivery by cesarean section. We do not require that a provider or other health care provider obtain *prior authorization* for the 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. Provider home visits and office services.
3. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
4. *Complications of pregnancy*.
5. *Hospital* stays for other *medically necessary* reasons associated with maternity care.
6. For medical services or supplies for maternity deliveries at home, required for medical professional or *medically necessary* treatment.

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

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

Duty to Cooperate

We do not cover services or supplies related to a *member's pregnancy* when *member* is acting as a *surrogate* and has entered into a *surrogacy arrangement* which covers the medical expenses of the *surrogate*. 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/tn/resources/handbooks-forms and send to:

Ambetter of Tennessee
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 provision on the basis of fraud, misrepresentation or false information, up to and including recoupment of all benefits that we paid on behalf of the *surrogate* during the time that the *surrogate* was insured under our *contract*, plus interest, attorneys' fees, costs and all other remedies available to us.

Note: This provision does not amend the *contract* to restrict any terms, limits or conditions that may otherwise apply to *surrogates* and children born from *surrogates*. Please reference GENERAL NON-COVERED SERVICES AND EXCLUSIONS section, as limitations may exist.

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 amounts*, *coinsurance* percentage, *deductible* and *maximum out-of-pocket amount*), as listed in the *Schedule of Benefits*. Please refer to the Dependent Member Coverage section of this document for details regarding the provisions for Coverage for a Newborn Child and Coverage for an Adopted Child.

Newborns' and Mothers' Health Protection Act Statement of Rights

Health insurance issuers generally may not, under federal law, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider,

after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain *authorization* from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

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

Medical and Surgical Expense Benefits

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

1. For *surgery* in a provider's office an *inpatient* facility, an *outpatient* facility or a surgical facility, including services and supplies.
2. For pre-surgical and post-surgical procedures and testing, including but not limited to, diagnostic services using radiologic, ultrasonographic or laboratory services:
   a. Laboratory tests or radiological examinations done on an *outpatient* basis in a *hospital* or other facility accepted by the *hospital* before *hospital* confinement or *outpatient surgery* or procedures. The tests must be for the same bodily *illness* or *injury* causing the *member* to be hospitalized or to have the *outpatient surgery* or procedure.
   b. Bone density studies.
   c. Clinical laboratory tests.
   d. Gastrointestinal laboratory procedures.
   e. Pulmonary function tests.
   f. Genetic testing.
   g. For *medically necessary* genetic or molecular cancer testing, including but not limited to, tumor mutation testing, next generation sequencing, hereditary germline mutation testing, pharmacogenomics testing, whole exome, genome sequencing and biomarker testing.
3. For medical services in an office or facility that is provided by a licensed *medical practitioner* or *specialist physician*, including consultations and *surgery* related services.
4. For elective sterilization procedures (e.g., vasectomies). **Note**: No cost-share applies, except for HSA-compatible plans.
5. For chemotherapy (including oral chemotherapy), inhalation therapy, infusion therapy, and radiation therapy or treatment in a *hospital* or office setting.

6. For *durable medical equipment*, *prosthetic devices*, *orthotic devices*, or other *necessary medical supplies* following a medical or *surgical procedure* such as crutches, orthopedic splints, braces, or casts. Please see the Durable Medical Equipment (DME) provision of this *contract*.
7. For hemodialysis and the charges by a *hospital* or facility for the processing and administration of genetic testing, blood, or blood components, including cost of blood, blood plasma and blood plasma expanders, which is not replaced by or for you.
8. For the cost and administration of anesthesia, oxygen, drugs, medications, and biologicals.
9. For *medically necessary* reconstructive or cosmetic *surgery* including, but not limited to:
    a. Reconstructive breast *surgery* charges as a result of a partial or total mastectomy. Coverage includes *surgery* and reconstruction of the diseased and non-diseased breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedema.
    b. R*econstructive surgery* for craniofacial abnormalities.
10. For *medically necessary* dental *surgery* due to:
    a. An accidental *injury* which results in damage to natural teeth. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
    b. *Surgery* to correct a functional defect which results from a congenital and/or acquired disease or anomaly.
    c. Cleft lip and cleft palate for an eligible *member*. *Covered services* include medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the treating *physician* or surgeon and such *physician* or surgeon certifies that such services are *medically necessary* and consequent to treatment of the cleft lip or cleft palate.
    d. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* charges for dental care, rendered by a dentist, provided to the following *members*:
        i. A *member* whose treating *medical practitioner* in consultation with the dentist determines the *member* has a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or
        ii. A *member* who has one or more medical conditions that would create significant or undue medical risk for the *member* during delivery of any dental treatment or *surgery* if not rendered in a *hospital* or *ambulatory surgical center*.
        iii. Necessary dental treatment is that which, if left untreated, is likely to result in a medical condition. Use of general anesthesia in a *hospital* or *ambulatory surgical center* is subject to *prior authorization*. Please call Member Services to confirm your benefits for the use of general anesthesia in a *hospital* or *ambulatory surgical center*.

11. For infertility counseling and planning services when provided by a *network provider* and testing to diagnose infertility.
12. For the treatment of breast cancer by dose-intensive chemotherapy bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy bone marrow transplants or stem cell transplants.
13. For routine patient care for *members* enrolled in an eligible cancer clinical trial that is deemed an *experimental or investigational* treatment if the services provided are otherwise considered *covered services* under this *contract*. See the Clinical Trial Coverage provision of this *contract*.
14. For the following types of *medically necessary* implants and tissue grafts:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.
    e. Implantable prosthetic lenses, in connection with cataracts.
    f. Skin grafts.
15. For x-rays, Magnetic Resonance Imaging (MRI), Computed Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT), and other diagnostic services. See Radiology, Imaging and Other Diagnostic Testing provision of this *contract*.
16. For *medically necessary telehealth services*. *Telehealth services* not provided through *Virtual 24/7 Care* would be subject to the same *cost sharing* as the same health care services when delivered to a *member* in person.
17. For *surgery* or services related to cochlear implants and bone-anchored hearing aids.
18. For *medically necessary* services for complications arising from medical and surgical conditions.
19. For respiratory, pulmonary, cardiac, physical, occupational and speech therapy services. Please see Habilitation Rehabilitation, and Extended Care Facility Expense Benefits provision of this *contract*.
20. For children's early intervention therapy for expenses arising from the services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists and clinical social workers working with children from birth to 36 months of age with an identified developmental disability and/or delay.
21. For *medically necessary* footcare treatment that may require *surgery*; *prior authorization* may be required.
22. For 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 procedures.
25. *Medically necessary* nutritional counseling; *prior authorization* may be required.
26. For *medically necessary chiropractic care* or manipulative therapy treatment on an *outpatient* basis only.
27. For all *medically necessary* immunizations, monitoring, screenings, re-screenings and laboratory testing for a newborn in the early detection, diagnosis and intervention of a condition or disorder. This also includes, but not limited to, hearing or audiological services, follow-up examinations and pulse oximetry.
28. For *medically necessary* allergy testing and treatment including allergy injections and serum.
29. For expenses or services related to immunizations and vaccinations for travel purposes.
30. 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 dental care, 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. *Medically necessary* oral *surgery*, including, but not limited to, the following:
    a. Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;

b. Orthognathic *surgery* for a physical abnormality that prevents normal function of the upper and/or lower jawbone and is *medically necessary* to attain functional capacity of the affected part.

c. Oral/surgical correction of accidental *injuries*.

d. Treatment for temporomandibular joint (TMJ) disorder, including removable appliances for TMJ repositioning and related *surgery*, medical care, and diagnostic services.

e. Treatment of non-dental lesions, such as removal of tumors and biopsies.

f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

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

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

i. *Surgery* excluding tooth extraction to treat craniomandibular disorders, or malocclusions.

2. For *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

We cover medical foods and formulas for:

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

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

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

Low-Protein Food Products for Treating Inherited Metabolic Diseases

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

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

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

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

Medical Vision Services

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

Excluded services for routine and non-routine vision include:

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

Mental Health and Substance Use Disorder Benefits

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

Our *behavioral health* and *substance use disorder* staff oversees the delivery and oversight of covered *behavioral health* and *substance use disorder* services for Ambetter. If you need *mental health disorder* or *substance use disorder* treatment, you may choose any provider in our *behavioral health* and *substance use disorder* provider *network* . You can search for *network behavioral health* providers by accessing our "Find a Doctor" page at AmbetterHealth.com/en/tn or by calling Member Services. *Deductible amounts*, *copayment* or *coinsurance amounts* and treatment limits for covered *behavioral health* benefits will be provided on the same terms and conditions as medical and surgical benefits.

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

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

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

Inpatient

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

Outpatient

1. Evaluation and assessment for *mental health* and *substance use disorder*s;
2. Individual, family, and group therapy, for *mental health disorder*s and *substance use disorder*s;
3. Medication management services;

4. *Outpatient* detoxification programs;
5. Psychological and neuropsychological testing and assessment;
6. Medication Assisted Treatment – combines behavioral therapy and medications to treat *substance use disorders*;
7. *Applied behavior analysis*;
8. Telehealth; (individual/family therapy; medication monitoring; assessment and evaluation);
9. Partial Hospitalization Program (PHP);
10. Intensive Outpatient Program (IOP);
11. Mental health day treatment;
12. Electroconvulsive Therapy (ECT); and
13. *Transcranial magnetic stimulation (TMS)*.

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

Office visits include individual therapy, group therapy, routine evaluation and management, medication monitoring/management, nutritional counseling, urgent care and *telehealth services*.

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

Services will be provided on an *inpatient* and *outpatient* basis for the treatment of *mental health disorder* and *substance use disorder* diagnoses.

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

Pediatric Vision Benefits – Children under the age of 19

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

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

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

Services not covered:

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

Prescription Drug Expense Benefits

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

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

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

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

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

How to Fill a Prescription

Prescriptions 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/tn on the “Find a Doctor” page. You can also call Member Services to help you find a pharmacy. At the pharmacy, you will need to provide the pharmacist with your prescription and your *member* identification card.

We also offer a three-month (90-day) supply of maintenance medications by mail or from *network* retail pharmacies for specific benefit plans. These drugs treat long-term conditions or

illnesses, such as high blood pressure, asthma and diabetes. You can find a list of covered medications on AmbetterHealth.com/en/tn. You can also request to have a copy mailed directly to you.

Mail Order Pharmacy/Prescription Drug Delivery

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

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.

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

Insulin

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

Self-injectable Drugs

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

Formulary or Prescription Drug List

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

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.

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the formulary. For the most current formulary or *prescription drug* list or for more information about our pharmacy program, visit AmbetterHealth.com/en/tn or call Member Services.

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

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.

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.

Non-Covered Services and Exclusions:

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

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance unless such treatment is listed on the formulary.
2. For weight loss *prescription drugs* unless otherwise listed on the formulary.
3. For immunization agents otherwise not required by the Affordable Care Act.
4. For medication that is to be taken by the *member*, in whole or in part, at the place where it is dispensed.

5. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
6. For a refill dispensed more than 12 months from the date of a *physician's* order.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are listed on the formulary.
9. For drugs labeled "Caution - limited by federal law to *investigational* use" or for *investigational or experimental* drugs.
10. For any drug that we identify as therapeutic duplication through the drug *utilization review* program.
11. For more than a 30-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. Please note that only the 90-day supply may be subject to the discounted *cost sharing*. Mail orders less than 90 days are subject to the standard *cost sharing* amount.
12. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
13. For foreign prescription medications, except those associated with an emergency medical condition while you are travelling outside the United States, or those you purchase while residing outside the United States. These exceptions apply only to medications with an equivalent FDA-approved prescription medication that would be covered under this document if obtained in the United States.
14. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventive treatment is related to *member's* vacation during out of country travel. This section does not prohibit coverage of treatment of aforementioned diseases.
15. For medications used for cosmetic purposes.
16. For infertility drugs unless otherwise listed on the formulary.
17. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
18. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
19. For any drug dispensed from a non-lock-in pharmacy while *member* is in lock-in program.
20. For any drug related to *surrogate pregnancy* which is covered under a surrogacy agreement where the *surrogate* receives payment for medical expenses.

21. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
22. For medication refills where a *member* has more than 15 days' supply of medication on hand.
23. For compound drugs, unless there is at least one ingredient that is an FDA approved drug.
24. For drugs or dosage amounts determined by Ambetter's Pharmacy and Therapeutics Committee to be ineffective, unproven or unsafe for the indication for which they have been prescribed, regardless of whether such drugs or dosage amounts have been approved by any governmental regulatory body for that use.

Prescription Drug Exception Process

Standard exception request

A *member*, a *member's authorized representative* or a *member's* prescribing provider 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 provider 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 provider may request an expedited review based on exigent circumstances. Exigent circumstances exist when a *member* is suffering from a health condition that may seriously jeopardize the *member's* life, health, or ability to regain maximum function or when a *member* is undergoing a current course of treatment using a non-formulary drug. The request can be made in writing or via telephone. Within 24 hours of the request being received, we will provide the *member*, the *member's authorized representative* or the *member's* prescribing provider 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 provider 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 provider of our coverage determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request if the original request was an expedited exception.

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

will provide coverage of the non-formulary drug or the drug that is the subject of the protocol exception for the duration of the exigency.

Step Therapy Standard and Urgent Exception Requests.

A *member*, a *member's authorized representative* or a *member's* prescribing *physician* may request a standard or expedited review of a decision that a drug is a protocol exception for step therapy. The request can be made in writing or via telephone. Within 2 business days 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 step therapy protocol exception request be granted, we will provide coverage of the drug that is the subject of the protocol exception for the duration of the prescription, including refills.

Drug Discount, Coupon or Copay Card

Cost sharing paid on your behalf through a *drug discount, coupon, copayment* assistance program, or *manufacturer supplied prepaid credit card* for a *prescription drug* that has a generic equivalent will not apply toward your *deductible* or *maximum out-of-pocket amount*. However, such amounts will apply toward your *deductible* and *maximum out-of-pocket amount* if you have obtained access to the brand name *prescription drug* through *prior authorization*, a step therapy protocol, our exceptions and *appeals* process, or as otherwise required by Tennessee law.

Generic Medication

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

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:

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).

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).

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).

With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA to the extent the care is not illegal under *applicable law*.

Preventive care benefits obtained from a *network provider* are covered without *member cost share* (i.e., covered in full without *deductible*, *coinsurance* or *copayment*). For current

information regarding available preventive care benefits, please access the federal government's website at: www.healthcare.gov/coverage/preventive-care-benefits/.

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

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

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

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

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

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/tn To request a paper copy, please contact Member Services for assistance.

Prostate Specific Antigen Testing

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

Radiology, Imaging and Other Diagnostic Testing

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

may be incurred - both subject to any applicable *cost sharing* - one for the technical component (the procedure itself) and another for the professional component (the reading/interpretation of the results by a *physician* or other qualified practitioner).

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

Second Medical Opinion

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

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

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

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

Sleep Studies

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

Transplant Services

Covered services for transplant service expenses:

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

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

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

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

1. Pre-transplant evaluation.
2. Pre-transplant harvesting of the organ from the donor.
3. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
4. Including *outpatient covered services* related to the transplant *surgery*, pre- transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection, and other immunosuppressive drug therapy, etc.
5. Pre-transplant stabilization, meaning an *inpatient* stay to medically *stabilize* a *member* to prepare for a later transplant, whether or not the transplant occurs.
6. The transplant itself, including the acquisition cost for the organ or bone marrow when *authorized* through the *Center of Excellence* and services are performed at a *network* facility.
7. Post-transplant follow-up visits and treatments.
8. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.
9. All costs incurred and medical expenses by the donor; shall be paid under the transplant recipient *contract*, this excludes travel, lodging, food, mileage.

NOTE: Please refer to the “Member Transplant Travel Reimbursement Policy” for outlined details on reimbursement limitations at AmbetterHealth.com/en/tn.

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

Ancillary "Center of Excellence" Service Benefits

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

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

Note: Please refer to the “Forms and Materials” page for travel reimbursement forms and information at Ambetterhealth.com/en/tn/resources/handbooks-forms/.

Non-Covered Services and Exclusions:

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

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the *Center of Excellence*.
4. To keep a donor alive for the transplant operation, except when *authorized* through the *Center of Excellence*.
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.

6. Related to transplants unauthorized though the *Center of Excellence* and is not included under this provision as a transplant.
7. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (FDA) regulation, regardless of whether the trial is subject to FDA oversight.
8. The acquisition cost for the organ or bone marrow, when provided at an unauthorized facility or not obtained through the *Center of Excellence*.
9. For any transplant services and/or travel related expenses for *member* and donor, when preformed outside of the United States.
10. The following ancillary items listed below, will not be subject to *member* reimbursement under this *contract*:
    a. Alcohol/*tobacco*.
    b. Car, trailer, or truck rental (unless pre-approved by Case Management).
    c. Vehicle maintenance for motorized and hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.)
    d. Parking (unless pre-approved by Case Management).
    e. Storage rental units.
    f. Temporary housing incurring rent/mortgage payments.
    g. Loss of wages due to time off from work required for transplant for recipient, donor, or companion(s).
    h. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
    i. Moving violation tickets or parking tickets.
    j. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.).
    k. Any services related to pet care, boarding, lodging, food, and/or travel expenses.
    l. Expenses for persons other than the transplant recipient, donor or their respective companion(s).
    m. Expenses for lodging when the transplant recipient, donor, or their respective companion(s) are staying with a relative, friend, or otherwise have free lodging.
    n. Any expense not supported by a receipt.
    o. Upgrades to first class travel (air, bus, and train).
    p. Personal care items (e.g., shampoo, deodorant, clothes).
    q. Luggage or travel related items including passport/passport card, REAL ID travel IDs, travel insurance, TSA pre-check, and early check-in boarding fees, extra baggage fees.
    r. Souvenirs (e.g., t-shirts, sweatshirts, toys).
    s. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type.

t. All other items not described in the *contract* as *eligible 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 provider*s and services provided at an *urgent care center* including facility costs and supplies. Care that is needed after a *PCP's* normal business hours is also considered to be urgent care. Your zero-*cost sharing* preventive care benefits may not be used at an *urgent care center*.

Members are encouraged to contact their *PCP* for an appointment before seeking care from another provider, but contracted *urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *PCP* is not available and the condition persists, call the 24/7 Nurse Advice Line at 1-833-709-4735 (Relay 711). The 24/7 Nurse Advice Line is available 24 hours a day, seven days a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

Vision Benefits – Adults 19 years of age or older

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

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

Please refer to your *Schedule of Benefits* for a detailed list of *member cost sharing* and annual *maximum out-of-pocket amounts*. To see which vision providers are part of the *network*, please visit AmbetterHealth.com/en/tn 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 *contract*, we may offer wellness programs and other services to *members* that serve to remove barriers to accessing health services and improve overall health outcomes. These programs and services are available when your coverage begins and continue as long as your coverage remains active. Participation in these programs and services is optional and available at no additional cost to *members*. The programs and services are available to you as part of this *contract* but are not insurance. We may make changes to the terms and conditions of the programs and services or discontinue them at any time. Program tools and service may vary within your market. To inquire about these programs and other offerings, and to learn about what programs are available in your area, please visit our website at AmbetterHealth.com/en/tn or by contacting Member Services.

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

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

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

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

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *member* in the absence of insurance covering the charge, except for expenses incurred in connection with individual or group *hospital*, medical or surgical policy issued, delivered, amended or renewed on or after March 17, 1982, or employer or other entity that administers health, medical, or surgical insurance or that has an insurance company administering its health services program, shall except, limit, or reduce benefits or otherwise fail to pay for services rendered by a non-governmental charitable research *hospital*.
2. Expenses, fees, taxes, or surcharges imposed on the *member* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.
3. Any services performed by a *member* of the *member's immediate family*.
4. Any services not identified and included as *covered services* under the *contract*. You will be fully responsible for payment for any services that are not *covered services*.
5. Any services where other coverage is primary to Ambetter must be first paid by the primary payor prior to consideration for coverage under Ambetter.
6. Any non-medically necessary court ordered care for a medical/surgical or *mental health disorder*/*substance use disorder* diagnosis, unless required by state law.

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

1. Administered or ordered by a 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 services will not include, and no benefits will be provided or paid for any charges that are incurred:

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*.
2. For any portion of the charges that are in excess of the *eligible expense*.
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*, and bariatric *surgery*, except as specifically covered in the Major Medical Expense Benefits section of the *contract*.
4. For weight loss programs, gym memberships, exercise equipment, or meal preparation programs.
5. For the reversal of elective sterilization procedures.
6. For abortions unless performed to save the life of the *member* and not illegal under *applicable law*.
7. For expenses for television, telephone, or expenses for other persons.

8. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
9. For telephone consultations between *physicians*, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
10. For stand-by availability of a *medical practitioner* when no treatment is rendered.
11. For *dental services*, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery* except as expressly provided for under Major Medical Expense Benefits.
12. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect.
13. For the treatment of infertility except as expressly provided in this *contract*.
14. For *mental health disorder* services, the following are excluded:
    a. School funded/administered services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
    b. Pre-marital counseling;
    c. Court-ordered care or testing or required as a condition of parole or probation. Benefits will be allowed for services that are *medically necessary* and would otherwise be covered under this *contract*;
    d. Testing of aptitude, ability, intelligence, or interest; and
    e. Evaluation for the purpose of maintaining employment. Benefits will be allowed for services that would otherwise be covered under this *contract*.
15. For Assertive Community Treatment (ACT)
16. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
17. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
18. For *members* while confined primarily to receive *rehabilitation*, *custodial care*, educational care, or nursing services (unless expressly provided for in this *contract*).
19. For vocational or recreational therapy, vocational *rehabilitation*, *outpatient* speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
20. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
21. For hearing aids, except as expressly provided in this *contract*.
22. For *experimental or investigational* treatment(s) or *unproven services*. The fact that an *experimental or investigational* treatment or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational* treatment or *unproven service* for the treatment of that particular condition.

23. 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, by workers' compensation insurance pursuant to *applicable law*. If you enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's* workers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
24. For fetal reduction *surgery*.
25. Except as specifically identified as a *covered service* under the *contract*, services or expenses for alternative treatments, including acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
26. 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).
27. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
28. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
29. For expenses or services related to immunizations and vaccinations for occupational purposes.
30. For the following miscellaneous items (except where required by federal or state law): Artificial Insemination; blood and blood products; care or complications resulting from non-covered services; 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 state or federal law; care or services provided to a non-member biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *rehabilitation* services for the enhancement of job, athletic, or recreational performance; routine or elective care outside the *service area*; treatment of spider veins; transportation expenses, unless specifically described in this *contract*.
31. For diagnostic testing, laboratory procedures screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.

32. For court ordered testing or care unless *medically necessary*.
33. For a *member's illness* or *injury* which is caused by the acts or omissions of a *third-party*, we will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third-party*, which is designated for medical expenses.
34. For any medicinal and recreational use of cannabis or marijuana.
35. 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 related to a *surrogacy arrangement*;
    k. Pre-counseling, advice on procreation, or consultations related to gestational carriers or donor services;
    l. Any corrective surgeries or laparoscopic procedures for the sole purpose of *surrogacy arrangement*; or
    m. Any other medical or healthcare services related to the *pregnancy* or preparations to become a *surrogate* or donor.

    Any and all other health care services, supplies or medication provided to any child birthed by a *surrogate* as a result of a *surrogacy arrangement* are also excluded, except when the child has an active *contract* with us effective at the time of birth.
36. The following health care services, including supplies and medication to a non-member serving as a *surrogate*/gestational carrier pursuant to a *surrogacy/gestational carrier arrangement* with a *member* are excluded. This exclusion applies to all health care services, supplies and medication to the non-covered *surrogate*/gestational carrier 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*/gestational carrier following childbirth);

d. Mental health services related to the *surrogacy/gestational carrier arrangement*;

e. Expenses related to donor semen, including collection and preparation for implantation;

f. Donor gamete or embryos or storage of same relating to a *surrogacy/gestational carrier arrangement*;

g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy/gestational carrier arrangement*;

h. Preimplantation genetic diagnosis relating to a *surrogacy/gestational carrier arrangement*;

i. Any complications of the *surrogate*/gestational carrier resulting from the *pregnancy*; or

j. Any other health care services, supplies and medication relating to the *surrogacy/gestational carrier arrangement*.

37. For all health care services obtained at an urgent care facility that is a *non-network provider*.

38. For expenses for services related to dry needling.

39. For expenses, services, and treatments from a specialist for conditions caused by contracted, injured, spasmed, bruised, and/or otherwise affected myofascial or connective tissue.

40. For expenses, services, and treatments from a naturopathic specialist for treatment of prevention, self-healing and use of natural therapies.

41. For expenses, services, and treatments from a naprapathic specialist for conditions caused by contracted, injured, spasmed, bruised, and/or otherwise affected myofascial or connective tissue.

42. For any and all health care services, supplies or medication provided to any child birthed by a *surrogate*/gestational carrier as a result of a *surrogacy/gestational carrier arrangement* are also excluded. This exclusion shall not apply where a *member* possessing an active *contract* with us is the intended parent of the child and/or the child possesses an active *contract* with us at the time of birth.

43. For expenses, services, and treatments related to private duty nursing in an *inpatient*, *outpatient* or home location.

44. 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.

45. For doula services.

46. For any specified sex-trait modification procedures, in accordance with federal regulations in 45 CFR § 156.115(d), which include any pharmaceutical or surgical intervention that is provided for the purpose of attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex either by intentionally:

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

TERMINATION

Termination of Contract

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

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

Refund upon Cancellation

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

Discontinuance

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

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

Notification Requirements

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

Continuation of Coverage

We will issue the continuation of coverage:

1. No less than 30 calendar days prior to a *member's* 26th birthday; or
2. Within 30 calendar days after the date we receive timely notice of your legal divorce or *dependent member's* marriage. Your former *dependent member* must pay the required premium within 31 calendar days following notice from us or the new *contract* will be void from its beginning.

SUBROGATION AND REIMBURSEMENT

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*.

However, if payment by or for the *third-party* has not been made by the time we receive acceptable *proof of loss*, we will pay regular *contract* benefits for the *member's loss*. We will have the right to be reimbursed to the extent of benefits we provided or paid for the *illness* or *injury* if the *member* subsequently receives payment from any *third-party*, which is designated for medical expenses. The *member* (or the guardian, legal representatives, estate, or heirs of the *member*) shall promptly reimburse us from the settlement, judgment, or any payment received from any *third-party*.

Our 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 homeowner's medical payments coverage or premises or homeowner's insurance coverage; and
5. Any other payments from a source intended to compensate a *member* for *third-party injuries*.

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

1. To fully cooperate with us in order to obtain information about the *loss* and its cause.
2. To immediately inform us in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.
3. To include the amount of benefits paid by us on behalf of a *member* in any claim made against any *third-party*.
4. If we are the primary insurer, to give us 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 and regardless of the *member's* own negligence).
5. If we are the primary insurer, to pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due to us 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 and regardless of the *member's* own negligence).
6. That we:

a. Will have a lien on all money received by a *member* in connection with the *loss* equal to the benefit amount we have provided or paid for a medical expense.
b. May give notice of that lien to any *third-party* or *third-party*'s agent or representative.
c. Will have the right to intervene in any suit or legal action to protect our rights.
d. Are subrogated to all of the rights of the *member* against any *third-party* to the extent of the benefits paid on the *member's* behalf.
e. May assert that subrogation right independently of the *member*.

7. To take no action that prejudices our reimbursement and subrogation rights.
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 no less than 30 calendar days prior to the settlement.
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; the *third-party*'s payment must be expressly designated as a payment for medical expenses.
11. That we may reduce other benefits under the *contract* by the amounts a *member* has agreed to reimburse us in relation to their claim.

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

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

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

GRIEVANCE AND APPEAL 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 healthcare services. The following processes are available to address your concerns:

Call Member Services

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

Grievances

Ambetter of Tennessee has a *grievance* procedure which allows you the opportunity to resolve your issues and *complaints*. You or your *authorized representative* (*claimant*) may file a *grievance*. The process is voluntary and is available for review of the *contract*, quality of care or quality of service issues that affect you. The *grievance* process does not apply to *grievances* based solely on the basis that the *contract* does not cover the service or limits benefits for the health care service in question, provided that the exclusion of the specific service requested is clearly stated in the *contract*.

Grievances may include, but are not limited to, the following concerns:

1. The issue may refer to any dissatisfaction about:
    a. Us, as the insurer; e.g., customer service *complaints* - “the person to whom I spoke on the phone was rude to me”;
    b. Providers with whom we have a direct or indirect *contract*;
        i. Lack of availability and/or accessibility of *network provider*s not tied to an unresolved benefit denial; and
        ii. Quality of care/quality of service issues;
2. Availability, delivery or quality of health care services;

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

Claimants should submit all documentation to us at:

Ambetter of Tennessee
ATTN: Appeals and Grievances Department
P.O. Box 10341
Van Nuys, CA 91410

Applicability/Eligibility

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

An eligible complainant is:

1. A *member*;
2. A person authorized to act on behalf of the *member*. **Note**: Written authorization is not required; however, if received, we will accept any written expression of authorization without requiring specific form, language, or format. Verbal consent to act on behalf can be given by calling Member Services;
3. A *spouse*, family member, or the treating provider, in the event the *claimant* is unable to give consent.
4. The person for whom the *member* has verbally given authorization to represent the *claimant* in the event of an expedited *grievance*.

Important: *Adverse benefit determinations* reviews are *appeals* and not *grievances* and will follow standard state and federal guidelines.

Filing a Grievance

Grievances may be requested by a *member*, the *member's authorized representative* or a provider acting on behalf of a *member*. *Grievances* may be filed orally by calling Member Services or in writing by mailing or faxing your *grievance* to:

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

Resolution Timeframes

Ambetter of Tennessee will issue a written decision, in clear terms, to you and your *authorized representative*, if applicable, within 30 calendar days after receiving the *grievance*. Ambetter of Tennessee may extend the timeframe for disposition of a *grievance* for up to 14 calendar days if the *member* requests the extension or if the *member* gives us consent.

Acknowledgement

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

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

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

3. A *grievance* submitted by an *authorized representative* will be processed regardless of whether health care information or medical records may be disclosed to the *authorized representative* under *applicable law*.

Right to Participate

A *claimant* or the *claimant's authorized representative*, who has filed a *grievance* has the right to submit comments to the *grievance* and *appeals* administrator that is responsible for the resolution of the *grievance*. The *claimant* or *authorized representative* is entitled to request a copy of documentation reviewed by the *grievance* and *appeals* administrator in making its determination. The *claimant* must submit questions or comments to the *grievance* and *appeals* administrator or external review organization in writing within a period of time provided in the notice to the *claimant* of the *grievance* process.

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* claim for benefits.

The *claimant* will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The plan will give the *claimant* ten calendar days to respond to the new information before making a determination.

Written Grievance Response

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

Our written determination to the *claimant* must include:

1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *grievance*;
3. A written description of position titles of the persons involved in making the decision;
4. A clear explanation of the decision;
5. Reference to the specific plan provision on which the determination is based;
6. A statement that the *claimant* is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *claimant* 's claim for benefits; and
7. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the *claimant* upon request.

Appeals

When we deny a claim for plan benefits you have already received (*post-service claim* denial) or we deny your request to *authorize* treatment or service (preservice denial), our decision is known as an *adverse benefit determination*. You, your *physician* or *authorized representative* can request an *appeal* of our decision. If we rescind your coverage or deny your application for coverage, you may also *appeal* our decision. When we receive your *appeal*, we are required to review our own decision.

Appeals must be filed in writing by you, your *authorized representative* or your provider acting on your behalf by filing the "Grievance & Appeals Form" found on the AmbetterHealth.com/en/tn/resources/handbooks-forms website. You may also send a written request with supporting documents to:

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

You can also file an *appeal* orally by contacting Member Services at 1-833-709-4735 (Relay 711). Your verbal request must be followed up in writing.

Right to Participate

A *member* or the *member's authorized representative* has the right to file an *appeal*.

A *member* or the *member's authorized representative*, who has filed an *appeal* can submit written comments, documents, records and other information to the Appeals and Grievances Department. The *member* or *member's authorized representative* is entitled to request a copy of the documentation reviewed by the Appeals and Grievances Department in making its determination. The *member* must submit questions or comments to the Appeals and Grievances Department in writing within a period of time provided in the notice to the *member* of the *appeals* process. .

Continuing Coverage

The plan cannot terminate your benefits until your *appeal* rights have been exhausted. However, if the plan's decision is ultimately upheld, you may be responsible to pay any outstanding claims or reimbursing the plan for claim payments it made during the time of the *appeals*.

Cost and Minimums for Appeals

There is no cost to you to file an *appeal* and there is no minimum amount required to be in dispute.

Rescission of Coverage

If the plan rescinds your coverage, you may file an *appeal* of that determination. The plan cannot terminate your benefits until your *appeal* rights have been exhausted. Since a

rescission means that no coverage ever existed, if the plan's decision to rescind is upheld, you will be responsible for payment of all claims for your health care services.

Time Limits for Filing an Appeal

You or your *authorized representative* must file the internal *appeal* within 180 calendar days of the receipt of the notice of denial (an *adverse benefit determination*). Failure to file within this time limit may result in the company's declining to consider the *appeal*.

Acknowledgement

Within five business days of receipt of an *appeal*, we will send a written acknowledgment to the *member*, the provider or the *member's authorized representative* confirming receipt of the *appeal*.

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

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

Resolution Timeframes

Appeals will be resolved, and we will notify you in writing with the *appeal* decision within the following timeframes:

1. Post service: within 60 calendar days after receipt of the request for internal *appeal*; or
2. Pre-service: within 30 calendar days after receipt of the request for internal *appeal*.

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

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

For *appeals* involving an *adverse benefit determination* with respect to concurrent review of urgent care requests involving an admission, availability of care, continued stay or healthcare service for a *member* who has received *emergency services*, but has not been discharged from a facility, the plan will handle these requests as *expedited appeals*.

The plan will advise you at the time a claim is denied that you can file an *expedited appeal*. You may also file for an expedited external review (see ‘Simultaneous urgent claim, *expedited appeal* and external review”).

Expedited appeal means *appeal* 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 *appeal*.

An *expedited appeal* may be submitted orally or in writing. All necessary information, including our determination on review, will be transmitted between the *member* and us by telephone, facsimile, or other available similarly expeditious method. An *expedited appeal* shall be resolved as expeditiously as the *claimant’s* health condition requires, but not more than the lesser of 48 hours from receipt of all information necessary to complete the *appeal*, or 72 hours after receipt of the *appeal*.

If the *expedited appeal* involves an *adverse benefit determination* with respect to a concurrent review of an urgent care request, the service shall be continued until the *member* or *member’s authorized representative* has been notified of the determination or until the health care provider determines that the urgent care is no longer appropriate or necessary. This does not apply to requests for extensions.

Upon written request, we will mail or electronically mail a copy of the *member’s* complete *contract* to the *member*, the provider, or the *member’s authorized representative* as expeditiously as the *appeal* is handled.

Simultaneous *expedited appeal* and external review:

1. You or your *authorized representative*, may request an *expedited appeal* and an expedited external review (see External Review provision) if both the following apply:
2. You have filed a request for an *expedited appeal*; and
3. After a *final adverse benefit determination*, if either or the following applies:
   a. Your treating *physician* certifies that the *adverse benefit determination* involves a medical condition that could seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, if treated after the timeframe of a standard external review;
   b. The *final adverse benefit determination* concerns an admission, availability of care, continued stay or health care service for which you received *emergency services*, but has not yet been discharged from a facility.

Written Appeal Response

Appeal response letter will be written in a manner to be understood by the *member*, the provider, or the *member's authorized representative* and the notification shall include the specific reasons for the denial, determination, or initiation of disenrollment.

Our written response letter will include:

1. The disposition of and the specific reason or reasons for the decision in clear terms and the medical rationale for the decision, if applicable
2. Any corrective action taken on the *appeal*;
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 plan or *contract* provision on which the determination is based;
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 benefit determination*, either the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the *adverse benefit determination* and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the *member* upon request;
9. If the *adverse benefit determination* is based on medical necessity or *experimental* treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the *member's* medical circumstances or a statement that such explanation will be provided free of charge upon request;
10. If applicable, instructions for requesting:

a. A copy of the rule, guideline, protocol or other similar criterion relied upon in making the *adverse benefit determination*.

b. The written statement of the criteria for the determination.

11. If applicable, a statement indicating:

a. A description of the process and procedures for requesting an external review of an *adverse benefit determination*, including any required timeframe for the review.

External Review

An external review is conducted by an *independent review organization (IRO)* that will review the final *appeal* decision and render a decision on whether to uphold or reverse the *adverse benefit determination*. 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.

Applicability/Eligibility

The external review procedures apply to:

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

An external review is available for *appeals* that involve:

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

External Review Procedure

After exhausting the internal review process, the *claimant* has six months to make a written request to the *grievance* and *appeals* administrator for external review after the date of receipt of our internal response.

1. The internal *appeal* process must be exhausted before the *claimant* may request an external review unless the *claimant* files a request for an expedited external review at the same time as an internal *expedited appeal* or we either provide a waiver of this requirement or fail to follow the *appeal* process;
2. 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 appeal* would seriously jeopardize the life or health of the *claimant* or would jeopardize the *claimant's* ability to regain maximum function and the *claimant* has filed a request for an internal *expedited appeal*; and

b. A final internal *adverse benefit determination*, if the *claimant* has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the *claimant* or would jeopardize the *claimant's* ability to regain maximum function, or if the final internal *adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service for which the *claimant* received *emergency services*, but has not been discharged from a facility;

3. *Claimants* may request an expedited external review at the same time the internal *expedited appeal* is requested (see procedures below).

External Review Process

1. We have ten business days (immediately for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether:

   a. The individual was a *member* at the time the item or service was requested;

   b. The service is a *covered service* under the *claimant's* health plan but for the plan's *adverse benefit determination* with regard to medical necessity *experimental/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 three business days (immediately for expedited) after completion of the preliminary review, we will notify the *claimant* in writing as to whether the request is complete but not eligible for external review and the reasons for its ineligibility or, if the request is not complete, the additional information needed to make the request complete;

3. We must allow a *claimant* to perfect the request for external review within the six-month filing period or within six business days following the receipt of notification;

4. We will assign an *IRO* on a rotating basis from our list of contracted *IROs*;

5. Within six business days after the date of assignment of the *IRO*, we must provide the documents and any information considered in making the *adverse benefit determination* to the *IRO*.

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

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

7. Within three business days, we will notify the *claimant* in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the *claimant* may submit in writing additional information to the *IRO* to consider;
8. Upon receipt of any information submitted by the *claimant*, the *IRO* must forward the information to us within one business day;
9. Upon receipt of the information, we may reconsider our determination. If we reverse our *adverse benefit determination*, we must provide written notice of the decision to the *claimant* and the *IRO* within one business day after making such decision. The external review would be considered terminated;
10. Within 40 calendar days 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 us within one business day of reaching its decision. We will then notify you of the *IRO*'s decision within three business days.
11. 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
12. 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*.

Expedited External Review

An external *expedited appeals* may be submitted orally or in writing. All necessary information will be transmitted between the *claimant* and us by telephone, facsimile, or other available similarly expeditious method and given by us to the *IRO*.

Ambetter will allow a *member* to make a request for an expedited external review with the plan at the time the *member* receives:

1. An *adverse benefit determination* if the determination involves a medical condition of the *member* for which the timeframe for completion of an internal *expedited appeal* would seriously jeopardize the life or health of the *member* or would jeopardize the *member's* ability to regain maximum function and the *member* has filed a request for an internal *expedited appeal*; and
2. A final internal *adverse benefit determination*, if the *member* has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the *member* or would jeopardize the *member*'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 *member* received *emergency services*, but has not been discharged from a facility.

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

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
Pre-service Appeal	180 Calendar Days	5 Business Days	30 Calendar Days	N/A
Expedited Pre-service Appeal	180 Calendar Days	N/A	72 Hours	N/A
Post-Service Appeal	180 Calendar Days	5 Business Days	60 Calendar Days	N/A
External Review	6 Months	Up to 13 Calendar Days	45 Calendar Days	N/A
Expedited External Review	6 Months	Immediately	72 Hours	N/A

Further Resources

The Tennessee Department of Commerce & Insurance is available to assist insurance consumers with insurance related problems and questions. You may inquire in writing at Consumer Insurance Services, 500 James Robertson Parkway, 10th Floor, Nashville, Tennessee 37243-0574 or contact the Department between the hours of 8 a.m. to 5 p.m. CST at 1-800-342-4029.

CLAIMS

Notice of Claim

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

Proof of Loss

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

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/tn/resources/handbooks-forms/. Send all the documentation to us at the following address:

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

Claims may also be sent to us at the following address:

Ambetter of Tennessee
6200 Hospitality Drive
Franklin, TN 37067

Cooperation Provision

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

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

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

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

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

Time for Payment of Claims

Benefits will be paid within 30 calendar days for clean claims on paper; electronic claims will be paid within 21 calendar days. "Clean claims" means a claim submitted by you or a provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. Claim payments that are not made within the specified timeframes shall bear interest at the annual percentage rate of twelve percent (12 percent) beginning on the date following the day on which the claim should have been paid. If we have not received the information we need to process a claim, we will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information. In those cases, we cannot complete the processing of the claim until the additional information requested has been received. We will make our request for additional information within 20 calendar days of our initial receipt of the claim and will complete our processing of the claim within 30 calendar days after our receipt of all requested information.

Payment of Claims

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

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

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

Claims Incurred for Emergency Services While Traveling Outside the United States

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

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

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

You may be entitled to assign benefits to a *hospital* or health care provider. We will reimburse a *hospital* or health care provider if your health insurance benefits are assigned by you in writing, and we approve the assignment.

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

No Third-Party Beneficiaries

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

Medicare

This provision describes how we coordinate and pay benefits when a *member* is also enrolled in Medicare and duplication of Coverage occurs. If a *member* is not enrolled in Medicare or receiving benefits, there is no duplication of Coverage and we do not have to coordinate with Medicare.

The benefits under this *contract* are not intended to duplicate any benefits to which *members* are entitled under Medicare.

Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status and will be adjudicated by us as set forth in this section. In cases where Medicare or another government program has primary responsibility, Medicare benefits will be taken into account for any *member* who is enrolled for Medicare. This will be done before the benefits under this health plan are calculated. When Medicare, Part A and Part B or Part C is primary, Medicare's allowable amount is the highest allowable expense.

When a person is eligible for Medicare benefits and Medicare is deemed to be the primary payer under Medicare secondary payer guidelines and regulations, we will reduce our payment by the Medicare primary payment and pay as secondary up to the Medicare allowable amount. However, under no circumstances will this plan pay more than it would have paid if it had been the primary plan.

Charges for services used to satisfy a *member's* Medicare Part B *deductible* will be applied in the order received by us. Two or more expenses for services received at the same time will be applied starting with the largest first.

This provision will apply to the maximum extent permitted by federal or state law. We will not reduce the benefits due any *member* because of a *member's* eligibility for Medicare where federal law requires that we determine its benefits for that *member* without regard to the benefits available under Medicare.

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

Medicaid Reimbursement

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

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

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

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

Custodial Parent

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

Upon request by the custodial parent, we will:

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

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

Physical Examination

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

Legal Actions

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

GENERAL PROVISIONS

Entire Contract

This *contract*, with the application, is the entire *contract* between you and us. No agent may:

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

Non-Waiver

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

Rescissions

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

1. The misrepresented fact is contained in a written application, including amendments, signed by a *member*;
2. A copy of the application, and any amendments, has been furnished to the *member(s),* or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to our determination to issue coverage to any *member*. A *member's* coverage will be voided/rescinded, and claims denied if that person performs an act or practice that constitutes fraud. "Rescind" has a retroactive effect and means the coverage was never in effect.

Repayment for Fraud, Misrepresentation or False Information

If a *member* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *contract* or in filing a claim for *contract* benefits, we have the right to demand that *member* pay back to us all benefits that we provided or paid during the time the *member* was covered under the *contract* but was not eligible. After two years from the *effective date* of coverage, action may only be taken in cases of fraudulent misstatements.

Conformity with Applicable Laws

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

Personal Health Information (PHI)

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

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

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

Language Assistance

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