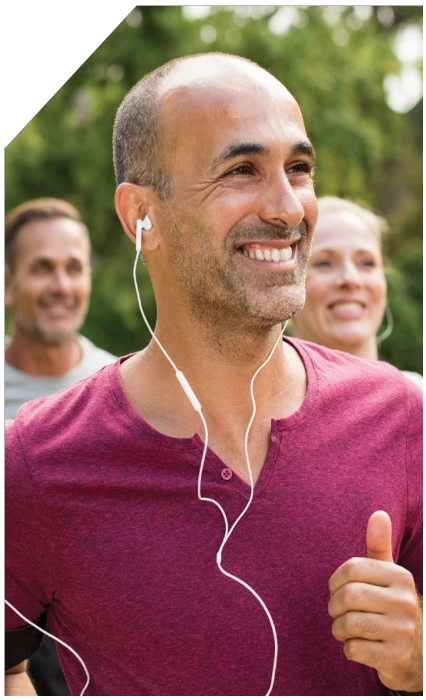
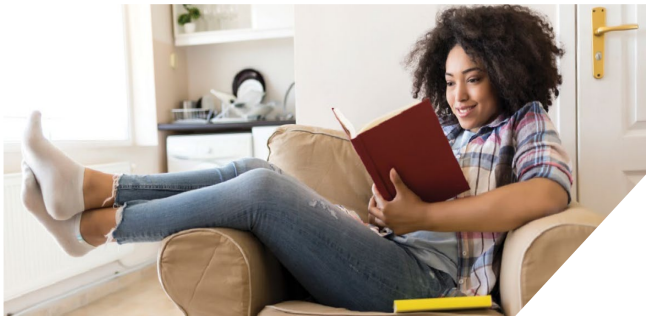
ambetter. FROM arkansas health & wellness





2027 EVIDENCE OF COVERAGE





AmbetterHealth.com/en/ar

AMBETTER FROM ARKANSAS HEALTH AND WELLNESS

Underwritten by QCA Health Plan, Inc.

Home Office: 1001 Technology Drive, Suite 401, Little Rock, AR 72223

Major Medical Expense Insurance Policy

In this *policy*, the terms "you" or "your" will refer to the *member* enrolled in this *policy* and "we," "our" or "us" will refer to Ambetter from Arkansas Health & Wellness.

AGREEMENT AND CONSIDERATION

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

Your coverage under this *policy* begins at 12:00 a.m. on the *effective date* and ends at 11:59 p.m. on the date this *policy* is terminated for any of the reasons described in this *policy*.

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 *policy* terms. You may keep this *policy* (or the new *policy* you are mapped to for the following year) in force by timely payment of the required premiums. In most cases you will be moved to a new *policy* each year, however, we may decide not to renew the *policy* as of the renewal date if: (1) we decide not to renew all *policy* issued on this form, with a new *policy* at the same metal level with a similar type and level of benefits, to residents of the state where you then live; (2) we withdraw from the *service area*; or (3) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *covered services*.

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

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

At least 31 calendar days' notice of any plan to take action or make a change permitted by this clause will be delivered to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under this *policy* or a change in a

member's health. While this *policy* is in force, we will not restrict coverage already in force. Changes to this *policy* will be approved by the Arkansas Insurance Department.

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

You are required to enroll each year in order to receive any subsidies for which you may be eligible.

RIGHT TO RETURN POLICY

Please read your *policy* carefully. If you are not satisfied, return this *policy* to us or to our agent within 10 calendar days after you receive it. All premiums paid will be refunded, less claims paid, back to the original method of payment and/or payor. The *policy* will be considered null and void from the *effective date*.



John Ryan
CEO and Plan President

Arkansas Insurance Department Notice

Arkansas Health & Wellness
Ambetter from Arkansas Health & Wellness
P.O. Box 25408
Little Rock, AR 72221
Member Services 1-877-617-0390
TTY line 1-877-617-0392

If we at QCA Health Plan, Inc. fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department (AID)
1 Commerce Way, Suite 102
Little Rock, AR 72202

(800) 852-5494 or (501) 271-2640

You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 271-2640, complete the complaint form online by visiting https://www.insurance.arkansas.gov/pages/consumer-services/,or write the Department at 1 Commerce Way, Suite 102, Little Rock, AR 72202.

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INTRODUCTION

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

This *policy*, your *Schedule of Benefits*, the enrollment application as submitted to the Health Insurance Marketplace or QCA Health Plan, Inc., and any amendments or riders attached shall constitute the entire *policy* under which *covered services* and supplies are provided or paid for by us.

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

How to Contact Us

Arkansas Health & Wellness
Ambetter from Arkansas Health & Wellness
P.O. Box 25408
Little Rock, AR 72221

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

Member Services 1-877-617-0390
TTY line 1-877-617-0392
Fax 1-877-617-0393
Emergency 911
Suicide and Crisis Lifeline: 988 (call or text)
24/7 Nurse Advice Line 1-877-617-0390 or for hard of hearing (TTY 1-877-617-0392)

Interpreter Services

Ambetter from Arkansas Health & Wellness has a free service to help our members who speak languages other than English. These services ensure that you and your provider can talk about your medical or *behavioral health* concerns in a way that is most comfortable for you. Our interpreter services are provided at no cost to you. We have medical interpreters to assist with languages other than English via phone. An interpreter will not go to a provider's office with you. Members who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation, or to request materials in Braille or large font.

To arrange for interpretation services, please call Member Services.

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

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

You have the right to:

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

7. Candidly discuss with your *physician* and *medical practitioners* appropriate and *medically necessary* care for your condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *PCP* about what might be wrong (to the level known), treatment and any known likely results. Your *PCP* can tell you about treatments that may or may not be covered by the *policy*, regardless of the cost. You have a right to know about any costs you will need to pay. This should be told to you in words you can understand. When it is not appropriate to give you information for medical reasons, the information can be given to a legally *authorized representative.* Your provider will ask for your approval for treatment unless there is an emergency and your life and health are in serious danger.
8. Make recommendations regarding *member's* rights, responsibilities and policies.
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, authorizations, benefit denials, *member* rights and responsibilities, and our other rules and guidelines.
12. A current list of *network providers*.
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, sex, 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 *physician*(s) of the medical consequences. You are responsible for your actions if treatment is refused or if the *physician*'s instructions are not followed. You should discuss all concerns about treatment with your *PCP*. Your *PCP* can discuss different treatment plans with you, if there is more than one option that may help you. You will make the final decision.
18. Select your *PCP* within the network. You also have the right to change your *PCP* or request information on network *physicians* 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 *physician* is your *PCP*.
20. An interpreter when you do not speak or understand the language of the area.
21. A second opinion by a network provider if you want more information about your treatment or would like to explore additional treatment options.

22. Make advance directives for health care decisions. This includes planning treatment before you need it.
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 directives are forms you can complete to protect your rights for *medical care*. It can help your *PCP* and other *physicians* 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; and
    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 *policy*.
2. Treat all *healthcare professionals* and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about your health that we or your *medical practitioners* need in order to provide care. You should make it known whether you clearly understand your care and what is expected of you. You need to ask your provider questions 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 identification card, 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 *PCP*. 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. Follow the treatment plans and instructions for care that you have agreed on with your *healthcare professionals* and *physician*.
9. Tell your healthcare professional and *physician* if you do not understand your treatment plan or what is expected of you. You should work with your *PCP* to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.
10. Follow all health benefit plan guidelines, provisions, policies and procedures.
11. Use any emergency room only when you think you have a medical emergency. For all other care, you should call your *PCP*.

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

Health Management Programs Offered

Ambetter from Arkansas Health and Wellness offers the following health management programs:

1. Asthma;
2. Coronary artery disease;
3. Diabetes (adult and pediatric);
4. Hypertension;
5. Hyperlipidemia;
6. Low back pain; and
7. Tobacco cessation.

To inquire about these programs or other programs available, you may visit our website at AmbetterHealth.com/en/ar or by contacting Member Services.

IMPORTANT INFORMATION

Provider Directory

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

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

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

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

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

If you provide documentation that you received incorrect information from us about a provider's network status prior to a visit, you will only be responsible for the network *cost sharing* amount and the network *deductible* or *maximum out-of-pocket amount* shall be applied.

Member Identification Card

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

The member identification card will show your name, member identification number and *copayment amounts* required at the time of service. Any applicable *deductibles*, and any applicable out-of-pocket maximum limitations will also be accessible through the member identification card. If you do not get your member identification card within a few weeks after you enroll, please call Member Services. We will send you another card. A temporary

identification card can be downloaded from your secure consumer dashboard at member.ambetterhealth.com.

Website

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

Quality Improvement

We are committed to providing quality health care for you and your family. Our primary goal is to improve your health and help you with any *illness* or disability. Our program is consistent with National Committee on Quality Assurance (NCQA) standards and 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 providers*, to help us develop and monitor our program activities.
5. Investigating any *member* concerns regarding care received.

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

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

Protection from Balance Billing

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

DEFINITIONS

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

Wherever used in this *policy*:

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

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

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

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

Refer to the **Appeals, Grievance and External Reviews Procedure s**ection of this *policy* for information on your right to *appeal* an *adverse benefit determination*.

Allowed amount (also see Eligible expense) is the maximum amount we will pay a provider for a *covered service*. When a *covered service* is received from a *network provider*, the

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

Please note, if you receive services from a *non-network provider*, you may be responsible for the difference between the amount the provider charges for the service (billed amount) and the *allowed amount* that we pay. However, you will not be responsible for *balance billing* for non-network care that is subject to *balance billing protections* and otherwise covered under your plan. 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 review means *utilization review* of health care services performed or provided in an outpatient setting.

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

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

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

Applicable non-English language, with respect to an address in any United States county to which a notice is sent, a non-English language is an *applicable non-English language* if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

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

Authorization or authorized means our decision to 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 you in an internal *appeal* or external review process of an *adverse benefit determination* who is any of the following:

1. A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an *adverse benefit determination*;

2. A person authorized by law to provide substituted consent for a covered individual;
3. A family member but only when you are unable to provide consent.

Autism spectrum disorder means a condition diagnosed according to the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

Balance billing means a *non-network provider* billing you for the difference between the provider's charge for a service and the *Eligible expense*. *Network providers* may not balance bill you for *covered expenses*.

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

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

1. *Emergency services* provided to a *member*, as well as services provided after the *member* is *stabilized* unless the *member* gave *notice and consent* to be balance billed for the *post-stabilization services*;
2. Non-emergency health care services provided to a *member* at a *network hospital* or at a *network* ambulatory surgical center unless 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 includes both mental health and *substance use disorders*, encompassing a continuum of prevention, intervention, treatment and recovery support services.

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

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

Breast magnetic resonance imaging means a diagnostic tool that uses a powerful magnetic field, radio waves, and a computer to produce detailed pictures of the structures within the breast.

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

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

Center of Excellence means a hospital that specializes in a specific type or types of *medically necessary* transplants or other 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*.

Certified community health worker means an individual who:

1. Has completed a standardized community health worker training program; and
2. Is certified by the Arkansas Community Health Worker Association, in conjunction with the Division of Higher Education, to administer health care services within the scope of their certification.

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.

Claim involving urgent care means any claim for care or treatment with respect to the application of the time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the *member* or the ability of the *member* to regain maximum function, or,
2. In the opinion of a *physician* with knowledge of the *member's* condition, would subject the *member* to severe pain that cannot be adequately managed without the care or treatment is the subject of the claim.

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

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

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

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

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

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

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

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

Cost sharing means the *deductible amount*, *copayment amount* and *coinsurance amounts* 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 your *Schedule of Benefits*. When you receive *covered services* from a *non-network provider* in a *network* facility, or when you receive covered *emergency services* or air ambulance services, *cost sharing* may be based on an amount different from the *allowed amount*.

Cost sharing percentage means the percentage of *covered services* that is payable by us.

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

Covered service means an expense or service that is:

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

Craniofacial corrective surgery means the use of surgery to alter the form and function of the cranial facial tissues due to a congenital or acquired musculoskeletal disorder.

Custodial care is 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.

De minimis means something not important; something so minor that it can be ignored.

Deductible amount or ***Deductible*** means the amount that you must pay in a calendar year for *covered services* before we will pay benefits. For family coverage, there is a family *deductible*

amount that is two times the individual *deductible amount*. Both the individual and the family *deductible amounts* are shown in your Schedule of Benefits. The *deductible amount* will include any payments made on the *member's* behalf.

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

Dependent member means your 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*.

Diagnostic examination for breast cancer means a *medically necessary* and appropriate examination, as determined by a clinician who is evaluating you for breast cancer, to evaluate the abnormality in the breast that is:

1. Seen or suspected from a screening examination for breast cancer;
2. Detected by another means of examination; or
3. Suspected based on your medical history or your family's medical history.

Drug discount, coupon, copayment card, or manufacturer supplied prepaid credit card are 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 amount*) 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 *policy* for *covered services*.

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

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

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

Eligible expense means a covered expense as determined below.
For network providers: When a covered expense is received from a *network provider*, the eligible expense is the contracted fee with that provider.

1. For *non-network providers*, unless otherwise required by federal or Arkansas law, the *eligible expense* is as follows:

    a. When *balance billing protections* apply to a *covered service* or covered air ambulance service is 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. Except as provided under (2)(a) above, when a *covered expense* is received from a *non-network provider*, the *eligible expense* the negotiated fee that has been agreed upon by us and the provider, as payment in full. If there is no negotiated fee agreed to by the provider with us, the *eligible expense* is reimbursement as determined by us and as required by *applicable law*. In addition to applicable *cost sharing*, you may be *balance billed* for these services.

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

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

Emergency services means *covered services* needed to evaluate and *stabilize* an *emergency condition*. This includes a medical screening examination in a hospital emergency department or independent freestanding emergency department (including labor and delivery departments) 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 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 to a hospital within 48 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the *inpatient* setting is appropriate, and if appropriate, the number of days considered *medically necessary*. By contacting us, you may avoid financial responsibility for any *inpatient* care that is determined to be not *medically necessary* under your *policy*. If your provider does not contract with us, you may be financially responsible for any care we determine is not a *covered service* because it is not *medically necessary*. Care and treatment provided once you are *stabilized* is no longer considered *emergency services* under your *policy*. Continuation of care beyond what

is needed to evaluate or *stabilize* your condition in an emergency will not be a *covered service* unless we authorize the continuation of care and it is *medically necessary*.

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

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

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

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (FDA) regulation, regardless of whether the trial is subject to FDA oversight;
2. An unproven service;
3. Subject to FDA approval, and:
    a. It does not have FDA approval;
    b. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation;
    c. It has FDA approval but is being 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;
    d. 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*.
4. *Experimental or investigational* according to the provider's research protocols.

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

Final adverse benefit determination means an *adverse benefit determination* that is upheld at the completion of a health plan issuer's internal appeals process.

Gastric pacemaker means a medical device that uses an external programmer and implanted electrical leads to the stomach; and transmits low-frequency, high-energy electrical stimulation to the stomach to entrain and pace the gastric slow waves to treat gastroparesis.

Gastroparesis means a neuromuscular stomach disorder in which food empties from the stomach more slowly than normal.

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

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

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

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

Habilitation or Habilitation Services/Therapy means services provided in order for a person to attain and maintain skills and functioning that was never learned or acquired and is due to a disabling condition. These services may be performed in an *inpatient* or outpatient setting and include physical therapy, occupational therapy and speech therapy, developmental services and *durable medical equipment* for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder.

Habilitative Developmental Services means providing instructions in the areas of self-help, socialization, communication, cognition, and social/emotional skills. Examples include, but are not limited to, toileting, dressing, using fine motor skills, crawling, walking, categorization, expressing oneself (making wants and needs known), picture recognition, identifying letters, numbers, shapes, etc., appropriate play skills and coping mechanisms.

Healthcare professional means a *physician*, psychologist, nurse practitioner, or other healthcare practitioner licensed, accredited, or certified to perform health care services consistent with state law.

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

Home healthcare means care or treatment of an *illness* or *injury* at the *member's* home that is provided by a home healthcare agency and prescribed and supervised by a *physician*.

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

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

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

Hospital means an institution that:

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

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

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

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

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

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

Inpatient means that services, supplies, or treatment, for a medical condition or, *behavioral health* condition 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 for Special Care Units.

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

Language assistance means translation services provided if requested. Contact Member Service's if oral or written services are needed.

1. The plan or issuer must provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any *applicable non-English language* and providing assistance with filing claims and appeals (including external review) in any applicable non-English language;
2. The plan or issuer must provide, upon request, a notice in any applicable non-English language; and
3. The plan or issuer must include in the English versions of all notices, a statement prominently displayed in any *applicable non-English language* clearly indicating how to access the language services provided by the plan or issuer.

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

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

Maximum out-of-pocket amount means the maximum amount a *member* must pay towards *covered services* in the form of *cost sharing* according to the plan in which you enrolled. A *member's deductible amount*, *prescription drug deductible amount* (if applicable), *copayment amount* and *coinsurance amounts* all contribute to the *maximum out-of-pocket amount*. The individual *maximum out-of-pocket* and the family *maximum out-of-pocket amounts* (if applicable) are shown in your *Schedule of Benefits*. Please note: There are separate *maximum out-of-pocket amounts* for *network* benefits versus out of *network* 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 care means the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body and for transportation primarily for and essential to the provision of such care.

Medical foods means low-protein modified food products, amino-acid-based elemental formulas, extensively hydrolyzed protein formulas, formulas with modified vitamin or mineral content and modified nutrient content formulas.

Medical practitioner includes, but is not limited to, a *physician*, nurse anesthetist, physician's assistant, physical therapist, licensed mental health and *substance use* practitioners, nurse practitioners, audiologists, chiropractors, dentists, pharmacists, nurse anesthetists,

optometrists, podiatrists, psychologists or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy*: acupuncturist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, emergency medical technician, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Medically necessary or medical necessity means our decision as to whether any medical services, items, supplies or treatment *authorized* by a provider to diagnose and treat a *member's* '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 not *medically necessary* are not *eligible expenses*.

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

Mental health disorder means a condition- excluding those mental or behavioral disorders due to psychoactive substance use (or equivalent category) - that falls under any of the diagnostic categories listed in the mental, 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 plans, most individual plans sold outside of the Marketplace, Medicare, Medicaid, Children Health Insurance Program (CHIP), TRICARE, COBRA and plans sold through the Small Business Health Insurance Program (SHOP) Marketplace.

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

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

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

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

Network provider means any licensed person or entity that has entered into a contract directly or indirectly with Ambetter from Arkansas Health & Wellness to provide *covered services* to *members* enrolled under this *Policy* including but not limited to, *hospitals*, specialty *hospitals*, Urgent care facilities, *physicians*, pharmacies, laboratories and other health professionals within our *service area*. The most current published list for the network can be found at AmbetterHealth.com/en/ar.

Neurologic Rehabilitation Facility means an institution licensed as such by the appropriate state agency. A *neurological rehabilitation facility* must:

1. Be operated pursuant to law;
2. Be accredited by the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities;
3. Be primarily engaged in providing, in addition to room and board accommodations, rehabilitation services for *severe traumatic brain injury* under the supervision of a duly licensed *physician*; and
4. Maintain a daily progress record for each patient.

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 contracted with the plan as a *network provider*.

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

1. The *non-network provider* provides the *member* a written notice in the format required by applicable law that states the provider is a *non-network provider*, includes a good-faith estimate of the non-network provider's charges for the services, identifies any *prior authorization* or other limitations that may be required in advance of receiving the services, and clearly states that consent is optional and the *member* may seek care from a *network provider*.
2. The *non-network provider* provides the notice described above to the *member* at least 72 hours before the services are furnished, except that for services scheduled within 72 hours, the notice must be provided at least 3 hours before the services are furnished.

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

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

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

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

Other plan means any plan or *policy* that provides insurance, reimbursement, or service benefits for hospital, surgical, or medical expenses. This includes payment under group or individual insurance policies, automobile no-fault or medical pay, homeowner insurance medical pay, premises medical pay, nonprofit health service plans, health maintenance

organization *subscriber* contracts, self-insured group plans, prepayment plans, and Medicare when the *member* s enrolled in Medicare. *Other plan* will not include Medicaid.

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

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

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

Positron emission tomography means an imaging test that uses radioactive substances to visualize and measure metabolic processes in the body to help reveal how tissue and organs are functioning.

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

Rehabilitation facility means an institution or a separate identifiable hospital unit, section, or ward that is licensed by the state as a rehabilitation facility. It operates primarily to provide 24-hour primary care or rehabilitation of sick or injured persons as inpatients.
Rehabilitation facility does not include a facility primarily for rest, the aged, long-term care, assisted living, custodial care, nursing care, or for care of the mentally disabled.

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

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

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

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

Residential treatment facility (RTF) means a facility in which 24-hour, on-site and structured care (non-acute care) is provided for the evaluation, *stabilization* and treatment of *substance use* and *mental health disorders*. RTFs do not provide acute care. They are generally used as a step-down from more intensive/acute care settings. **Note**: The duration of stay covered under this *policy* for an RTF admission is based on *medical necessity*. ***Respite care*** means home healthcare services provided temporarily to a *member* in order to provide relief to the *member's* immediate family or other caregiver.

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

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

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

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

Severe traumatic brain injury means a sudden trauma causing damage to the brain as a result of the head suddenly and violently hitting an object or an object piercing the skull and entering brain tissue with an extended period of unconsciousness or amnesia after the *injury* or a Glasgow Coma Scale below 9 within the first 48 hours of *injury*.

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

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

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

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

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

Spouse means the person to whom you are lawfully married.

Stabilize 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*, as used when referring to a *member* who has experienced an *emergency condition*, means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of an individual's medical condition is likely to result from or occur during a *transfer*, if the medical condition could result in any of the following:

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

And in the case of a *member* having contractions, "*stabilize*" means such medical treatment as may be necessary to deliver, including the placenta.

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

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

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

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

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

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

Telemedicine or Telehealth services means the use of electronic information and communication technology to deliver health care services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient. *Telemedicine* or *telehealth services* include store-and-forward technology and remote patient monitoring. *Telemedicine* or *telehealth services* do not include audio-only communication unless the audio-only communication is real-time, interactive, and substantially meets the requirements for a health care service that would otherwise by a *covered service*. *Telemedicine* or *telehealth services* do not include the use of a facsimile machine, text messaging, or email.

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

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

Third-party means a person or other entity that is or may be obligated or liable to the *member* for payment of any of the *member's* expenses for *illness* or *injury*. The term "*third-party*" includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company.

Tobacco use or use of tobacco means *use of tobacco* by individuals who may use tobacco under federal and state law on average four or more times per week and within the six months immediately preceding the date application for this *policy* was completed by the member, including all tobacco products, 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.

Transfer means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

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

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

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

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

Utilization review means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Areas of review may include ambulatory review, *prior authorization*, 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 dependents become eligible for insurance on the latter of:

1. The date you became covered under this *policy*; or
2. The date of marriage to add a *spouse*; or
3. The date of an eligible newborn's birth; or
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; or
5. The date a foster child is placed in your custody; or
6. The date a domestic partnership is established, pursuant to state law.

Effective Date for Initial Dependent Members

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

Coverage for a Newborn Child

An *eligible child* born to a *member* will be covered from the time of birth provided that (1) notice of the newborn is given to us by the Health Insurance Marketplace within 90 calendar days from birth, and (2) premium billed for this 90-day period, is timely paid under the terms of this *policy* and its grace period after such notice. The newborn child will be covered from the time of birth until the 91st day after birth. *Covered expenses* shall also include routine nursery care, pediatric charges for a well newborn child for up to five full calendar days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time. Each type of *covered service* incurred by the newborn child will be subject to the *cost sharing* amount listed in your *Schedule of Benefits*.

If notice is not provided within 90 calendar days after birth, or premium for such ninety (90) day period is not timely paid after such notice under the terms of this *policy* and its grace period, coverage for the newborn will not be effective and the newborn cannot be enrolled until the next open enrollment period.

Coverage for an Adopted Child

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

loss due to *injury* and *illness*, including *medically necessary* care and treatment of conditions existing prior to the date of placement.

Unless an application is received within 60 calendar days of petition of adoption, and premium is timely paid for the first 60 calendar days under the terms of this *policy* and its grace period, coverage for the adopted child will not be effective and the adopted child cannot be enrolled until the next open enrollment period. Coverage for an adopted child shall terminate upon the dismissal or denial of a petition for adoption.

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

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

Adding Other Dependent Members

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

ELIGIBILITY AND ENROLLMENT

For All Covered Persons

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

1. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *policy* or the date that we have not received timely premium payments in accordance with the terms of this *policy*;
2. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact;
3. The date of termination that the Health Insurance Marketplace provides us upon your request of cancellation to the Health Insurance Marketplace, or if you enrolled directly with us, the last day of the month in which we receive a request from you to terminate this *policy*, or any later date stated in your request will be effective the last day of the requested month but no further than 60 calendar days in advance;
4. The date we decline to renew this *policy*, as stated in the Discontinuance provision; or
5. The date of a *member's* death;
6. The *subscriber* resides outside the service area or moves permanently outside the *service area* of this plan; or
7. The date a *member's* eligibility for insurance under this *policy* ceases due to losing *network* access as the result of a permanent move.

If you have material modifications (examples include a change in life event (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 the Member Services Department.

For Dependent Members

A *dependent member* will cease to be a *member* at the end of the premium period in which the *member* ceases to be your dependent due to divorce or if a child ceases to be an *eligible child*. For eligible children, the Health Insurance Marketplace will send a termination letter with an *effective date* the thirty-first day of December the year the *eligible child* turns 26 years of age.

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

1. Not capable of self-sustaining employment due to mental disability or physical disability that began before the age limit was reached; and
2. Mainly dependent on you for support.

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

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

Open Enrollment

There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 1st of the current year, and extends through January 15th of the following year. *Qualified individuals* who enroll on or before December 15, 2026, will have an *effective date* of coverage on January 1, 2027.

Special Enrollment Periods

A *qualified individual* has 60 calendar days to report a qualifying event 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 or 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-1b for one or more calendar days during the 60 calendar days preceding the date of marriage;
3. An individual who was not previously a citizen, national, or lawfully present individual gains such status;
4. An individual who is no longer incarcerated or whose incarceration is pending the disposition of charges;
5. A *qualified individual*'s enrollment or non-enrollment in a *qualified health plan* is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, or employee, or agent of the Health Insurance Marketplace or Health & Human Services, or its instrumentalities as evaluated and determined by the Marketplace. In such cases, the Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or agent;
6. A *member* adequately demonstrates to the Health Insurance Marketplace that the *qualified health plan* in which the *member* is enrolled substantially violated a material provision of its *policy* in relation to the *member's* decision to purchase the *qualified health member plan* based on plan benefits, *service area* or premium;
7. 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;
8. At the option of the Exchange, the *qualified individual*, or his or her dependent:

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

9. A *qualified individual* or *member* gains access to new *qualified health plan*shealth plan 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 *member* or *dependent member* enrolled in the same plan has a change in eligibility for *cost sharing reductions*;
11. A *qualified individual* or dependent who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a *qualified health plan* or change from one *qualified health plan* to another one time per month;
12. A *qualified individual* or *member* demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by U.S. Department of Health & Human Services, that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide;
13. A *qualified individual* or dependent is a victim of domestic abuse or spousal abandonment and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
14. A *qualified individual* or dependent is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 calendar days after the qualifying event;
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* newly gains access to an employer sponsored Individual Coverage Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA);
17. A *qualified individual* or dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions or government subsidies completely cease; or

In the case of marriage, or in the case where *qualified individual* experience a *loss* of *minimum essential coverage*, the *effective date* is the first day of the following month.

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

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

Prior Coverage

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

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

PREMIUMS

Premium Payment

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

Grace Period

When a *member* is receiving a premium subsidy:

Premium payments are due in advance, on a calendar month basis. Monthly payments are due before the first day of each month for coverage effective during such month. After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last 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 & Human Services of the non-payment of premiums, the member, as well as providers of the possibility of denied claims when the *member* is in the second and third month of the grace period. We will continue to collect *advance premium tax credits* on behalf of the *member* from the Department of the Treasury, and will return the *advance premium tax credits* on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above. A *member* is not eligible to re-enroll once terminated, unless a *member* has a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

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

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

Third-party Payment of Premiums or Cost Sharing

We require each policyholder to pay his or her premiums and this is communicated on your monthly billing statements. Our payment policies were developed based on guidance from the Centers for Medicare and Medicaid Services (CMS) recommendations against accepting *third-*

party premiums. Consistent with CMS guidance, the following are the ONLY acceptable third parties who may pay 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 Individual Coverage Health Reimbursement Arrangement (ICHRA) or Qualified Small Employer Health Reimbursement Arrangement (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.

Health Savings Account (HSA)

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

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

This Evidence of Coverage is administered by Ambetter from Arkansas Health & Wellness and underwritten by QCA Health Plan, Inc. Neither entity is an HSA trustee, HSA custodian or a designated administrator for HSAs. QCA Health Plan, Inc., its designee and its affiliates, including Arkansas Health & Wellness, do not provide tax, investment or legal advice to members.

MEMBERS ARE SOLELY RESPONSIBLE FOR ADHERING TO ALL FEDERAL REGULATIONS AND GUIDELINES CONCERNING HSA MAXIMUM ALLOWABLE AMOUNT, CONTRIBUTIONS AND QUALIFIED WITHDRAWALS. IN ADDITION, EACH *MEMBER* WITH AN HSA IS RESPONSIBLE FOR NOTIFYING HIS/HER HSA CUSTODIAN OR TRUSTEE IF ENROLLMENT UNDER THEIR HSA PLAN HAS BEEN CANCELED OR TERMINATED.

THE TERMS OF THIS EVIDENCE OF COVERAGE ARE CONFINED TO THE BENEFITS PROVIDED HEREIN AND DO NOT ENCOMPASS ANY INDIVIDUAL HSA FEE ARRANGEMENTS, ACCOUNT MAINTENANCE OR CONTRIBUTION REQUIREMENTS, APPLICATION PROCEDURES, TERMS, CONDITIONS, WARRANTIES OR LIMITATIONS THERETO, GRIEVANCES OR CIVIL DISPUTES WITH ANY HSA CUSTODIAN OR TRUSTEE.

PLEASE CONSULT A PROFESSIONAL TAX ADVISOR FOR MORE INFORMATION ABOUT THE TAX IMPLICATIONS OF AN HSA OR HSA PROGRAM.

Misstatement of Age

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

Change or Misstatement of Residence

If you change your *residence*, you must notify the Health Insurance Marketplace to process your change 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 section on **Special Enrollment Periods** provision for more information.

Misstatement of Tobacco Use

The *member's* answer to the tobacco question listed on the *member's* enrollment application for coverage is material to our determination of premium. If a *member's use of tobacco* has been misstated on the *member's* application for coverage under this *policy*, we have the right to charge corrected premiums for the *policy* back to the original *effective date*.

COST SHARING FEATURES

Cost Sharing Features

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

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

Deductible

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

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

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

The amount payable will be subject to:

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

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

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 your *Schedule of Benefits*, are due at the time of service. Payment of a *copayment* does not exclude the possibility of a provider billing you for any non-covered services. *Copayments* do not count or apply toward the *deductible amount*, but do apply toward meeting your *maximum out-of-pocket amount*.

Coinsurance Percentage

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

Maximum Out-of-Pocket

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

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

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

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

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

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

The *maximum out-of-pocket amount* will include any payments made on a *member's* behalf.

The amount provided or payable will be subject to:

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

Non-Network Liability and Balance Billing

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

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

ACCESS TO CARE

Primary Care Physician (PCP)

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

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

*If you choose a nurse practitioner as your *PCP*, your benefit coverage and *copayment amounts* are the same as they would be for services from other *network providers*. See your *Schedule of Benefits* for more information. You may obtain a list of network *PCPs* at our website and accessing the "Find a Doctor" page or by calling the telephone number shown on the front page of this *policy*.

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

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

Changing Your PCP

You may change your *network PCP* for any reason, but not more frequently than once a month, by submitting a written request, online at our website at AmbetterHealth.com/en/ar, or by contacting our office at the number shown on your identification card. The change to your

network PCP of record will be effective no later than 30 calendar days from the date we receive your request.

Contacting Your PCP

To make an appointment with your *PCP*, call his/her office during business hours and set up a date and time. If you need help, call Member Services and we will help you make an 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. A licensed nurse is always available and ready to answer your health questions. If you are experiencing an *emergency condition*, call 911 or go to the nearest emergency room For a *behavioral health emergency condition*, call 988 or go to the nearest emergency room.

Service Area

Ambetter from Arkansas Health & Wellness operates in a *service area*, which covers the entire state. If you move from one county to another within the service area, your premium may change. Please refer to the **Premium** section for more information. If you move out of Arkansas, you are no longer eligible for coverage under this *policy* and may be eligible for enrollment into another *qualified health plan* during a special enrollment period.

Coverage Under Other Policy Provisions

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

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* in a timely manner of the termination and of their right to elect continued transitional care from the provider;
2. Provide the *member* with an opportunity to notify us of the *member's* need for transitional care; and
3. Permit the *member* to elect to continue receiving benefits for the course of treatment relating to their status as a continuing care patient during the period beginning on the date the notice described in (1) is provided and ending on the earlier of:
   a. 90 calendar days after the notice described in (1) is provided; or

b. The date on which the *member* is no longer a continuing care patient with respect to the provider.

We shall develop procedures to provide for the continuity of care of *members*. We shall ensure that:

1. When a *member* is enrolled in an Ambetter plan and is being treated by a *non-network provider* for a current episode of an acute condition, the *member* may continue to receive treatment as a *network* benefit from that provider until the current episode of treatment ends or until the end of 90 calendar days, whichever occurs first; and
2. When a provider's participation is terminated, the provider's patients under the plan may continue to receive care from that provider as a *network* benefit until a current episode of treatment for an acute condition is completed or until the end of 90 calendar days, whichever occurs first.

During the periods covered by (1) and (2) of this section, the provider shall be deemed to be a *network* provider for purposes of reimbursement, utilization management, and quality of care.

Emergency Services Outside of Service Area

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

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

Non-Emergency Services Outside of Service Area

If you are traveling outside of the Arkansas *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 Arkansas by searching the relevant state and the plan you are enrolled in on our provider directory at https://guide.ambetterhealth.com/. Not all states have Ambetter plans. If you receive care from an Ambetter provider outside of the *service area*, you may be required to receive *prior authorization* for non-emergency services. Contact Member Services at the phone number on your member identification card for further information. Except for emergency health services or services for *dependent members* residing outside the *service area*, there are no benefits available services received from a *non-network provider* located outside of the *service area.*
If you are temporarily out of the service area and have a medical or *behavioral health* emergency, call 911 or go to the nearest emergency room. Be sure to call us and report your emergency within one business day. You do not need *prior authorization* for emergency care services.

Hospital Based Providers

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

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

New Technology

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

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

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

Preferred Partnership

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

UTILIZATION MANAGEMENT

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

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

Authorization Requirements

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

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

1. Receives a service or supply;
2. Are admitted into a facility; 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*.

Network Exception: Before services are provided to a *member* at a *network* benefit level by an *non-network provider*, the *member's network provider* must notify us of the absence of or the exhaustion of all *network* resources resulting in *member's* need to seek care from a *non-network provider* for a *covered service*. If we approve *network* benefits for the requested care, then *network cost sharing amounts, maximum out-of-pocket amount* and other limits will apply to claims only for those services and supplies receiving the *prior authorization*.

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

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

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

1. At least 30 calendar days prior to the initial evaluation for organ transplant services.
2. At least 30 calendar days prior to receiving clinical trial services.

3. At least 5 calendar days prior to the start of home healthcare except members needing home health care after hospital discharge.

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

1. For urgent concurrent reviews, received at least 24 hours prior to the expiration of a previously approved course of treatment, within the lesser of one business day and 24 hours of receipt of the request. For all other urgent concurrent reviews, within the lesser of one business day and 72 hours of receipt of the request.
2. For urgent pre-service reviews, within one business day of receipt of all information to make a determination.
3. For non-urgent pre-service reviews, within two business days of receipt of all information necessary to complete a review.
4. For post-service or retrospective reviews, within 30 calendar days of receipt of the request.
5. For emergency services that requires immediate post-stabilization or post-evaluation, within 60 minutes of receipt of the request.

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

How to Obtain Prior Authorization

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

Failure to Obtain Prior Authorization

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

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

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

Prior Authorization Does Not Guarantee Benefits

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

Denial of Authorization

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

MAJOR MEDICAL EXPENSE BENEFITS

This *policy* provides coverage for health care services for members and *dependent members*. Some services require *prior authorization*. *Copayment*, *deductibles* and *coinsurance amounts* must be paid to your *network* provider or *non-network provider* at the time services are rendered. *Covered services* are subject to all *policy* provisions, including conditions, terms, limitations and exclusions. *Covered services* must be *medically necessary* and not *experimental or investigational*.
Limitations may apply to some *covered services* that fall under more than one *covered service* category. Please review limits carefully. Ambetter from Arkansas Health & Wellness will not pay benefits for any of the services, treatments, items or supplies that exceed benefit limits.

Essential health benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, *emergency services*, hospitalization, maternity and newborn care, mental health and *substance use disorder* services, including *behavioral health* treatment, *prescription drugs*, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. Essential health benefits provided within this *policy* are not subject to lifetime or annual dollar maximums. Coverage is limited to essential health benefits as required under *applicable laws*. Services that are not essential health benefits, and are not otherwise required to be covered under *applicable laws*, are not covered under this *policy*.

Ambulance Services

Air Ambulance Service Benefits

Covered services will include ambulance services for fixed wing transportation 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.
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*. Please Note: You should not be *balance billed* for covered air ambulance services.

Limitations
Benefits for air ambulance services are limited to:
1. Services requested by police or medical authorities at the site of an emergency.
2. Those situations in which the *member* is in a location that cannot be reached by ground ambulance.

Exclusions

No benefits will be paid for:

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

Ambulance Service Benefits (Ground and Water)

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

1. In cases where the *member* is experiencing an *emergency condition*, to the nearest hospital that can provide *emergency services* appropriate to the *emergency condition*; or
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; or
3. Transportation between *hospitals* or between a *hospital* and more appropriate level of care when *authorized* by Ambetter.
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*.

Benefits for ambulance services are limited to:

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

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

billed for services from a non-network ambulance provider, beyond your *cost share*, for ground and water ambulance services.

NOTE: You should not be *balance billed* for covered ground or water ambulance services.

Exclusions

No benefits will be paid for:

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

Autism Spectrum Disorder Benefits

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

1. Evaluation and assessment services;
2. *Applied behavior analysis* (ABA) therapy;
3. Behavior training and behavior management;
4. *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 *autism spectrum disorder* services. These services are subject to *prior authorization* to determine *medical necessity*. If multiple services are provided on the same day by different providers, a separate *copayment* and/or coinsurance will apply to each provider.

Breast Cancer Mammography, Ultrasound and Magnetic Resonance Imaging (MRI)

Covered expenses for a *member* shall include mammography screenings in accordance with USPSTF A and B rated guidelines and *applicable law*. Per *applicable law*, no *cost share* will be applied to diagnostic/supplemental examinations for breast cancer, including breast magnetic resonance imaging, mammograms and ultrasounds. 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** (exception): For HSA-compatible plans, the *deductible* cannot be waived for benefits that exceed the federal ACA preventive care requirements.

Care Management Programs

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

Chelation Therapy

Covered expenses for chelation therapy for control of ventricular arrhythmias or heart block associated with digitalis toxicity, emergency treatment of hypercalcemia, extreme conditions of metal toxicity, including thalassemia intermedia with hemosiderosis, Wilson's disease (hepatolenticular degeneration), lead poisoning and hemochromatosis is covered.

Chiropractic Services

Chiropractic services are covered when a chiropractor finds services are *medically necessary* to treat or diagnose neuromusculoskeletal disorders on an outpatient basis. *Covered service* expenses are subject to all other terms and conditions of the *policy*, including *copayments*, *deductible amount* and *cost sharing* percentage provisions. See the *Schedule of Benefits* for applicable *cost share* and limits.

Clinical Trial Coverage

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

Clinical trials must meet the following requirements:

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

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

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

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

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

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

Colorectal Cancer Screening

Colorectal cancer screenings are covered for *members* in accordance with applicable law and preventive care guidelines. Coverage includes colorectal cancer examinations and laboratory tests.

No *cost sharing* applies to preventive colorectal cancer screenings when provided by a *network provider*, including a follow-up colonoscopy performed as part of the preventive screening process after a positive or abnormal non-colonoscopy colorectal cancer screening test, as required by *applicable law*.

Diabetes 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 expenses* include, but are not limited to:

1. Examinations including podiatric examinations;
2. Routine foot care such as trimming of nails and corns;
3. Laboratory and radiological diagnostic testing;
4. Self-management equipment, and supplies such as urine and/or ketone strips;
5. Blood glucose monitor supplies, glucose strips for the device; and
6. Syringes or needles;
7. Orthotics and diabetic shoes;
8. Urinary protein/microalbumin and lipid profiles;
9. Educational health and nutritional counseling for self-management;
10. Eye examinations, and prescription medication; and
11. 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.

Covered expenses include:

1. Services provided in an outpatient dialysis facility or when services are provided in the home;
2. Processing and administration of blood or blood components;
3. Dialysis services provided in a hospital; and

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

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

Disposable Medical Equipment and 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 amount*, *copayment amount*, and *coinsurance amount*.

Durable Medical Equipment (DME), Medical and Surgical Supplies, Orthotic Devices and Prosthetics

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

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

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

1. The equipment, supply or appliance is worn out or no longer functions.
2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by a network *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

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

Covered services may include, but are not limited to:

1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for IV 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 the rental of one Continuous Passive Motion (CPM) machine per *member* following a covered joint surgery.
10. Rental of *medically necessary durable medical equipment* including: a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion and a ventilator.

Exclusions:

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

1. Air conditioners.
2. Ice bags/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.

Durable medical equipment and supplies may be subject to *prior authorization* as outlined in this policy except for wheelchairs, medical equipment and supplies otherwise classified, CPAPs and BIPAPs, oxygen equipment and supplies, diabetic drugs and supplies.

Medical and Surgical Supplies

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

Covered services may include, but are not limited to:

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

Exclusions:

Non-covered services include but are not limited to:

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

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. For artificial eyes and polishing of such;
5. For larynx, breast prosthesis, or basic artificial limbs. If more than one prosthetic device can meet a *member's* functional needs, only the charge for the most cost-effective prosthetic device will be considered a *covered expense*. Coverage provided for eligible charges shall be no less than eighty percent of Medicare allowable as defined by the Centers for Medicare & Medicaid Services, Healthcare Common Procedure Coding System;
6. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
7. 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.
8. Cochlear implant.
9. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
10. Restoration prosthesis (composite facial prosthesis).
11. Wigs (not to exceed one per calendar year).

Exclusions

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

1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.

4. Penile prosthesis when *medical necessity* criteria are not met or is strictly a cosmetic procedure.

Orthotic devices

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

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

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

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

Exclusions

Non-covered services include but are not limited to:

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

Electrotherapy stimulators

Covered expenses include using Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve *injury* when that pain is unresponsive to medication. Coverage is also provided for Neuromuscular Electrical Stimulation (NMES) for treatment of disuse atrophy where nerve supply to the muscle is intact, including but not limited to atrophy

secondary to prolonged splinting or casting of the affected extremity, contracture due to scarring of soft tissue, as in burn lesions and hip replacement *surgery*, until orthotic training begins.

Emergency Services

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

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

Enteral Feedings

Coverage for enteral feedings when such have been approved and documented by a provider as being the *member's* sole source of nutrition. Enteral feedings require *prior authorization* by *care management*.

Family Planning and Contraception Services

Family planning and contraceptive 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 the Health Resources and Services Administration (HRSA).

1. The full range of contraceptives currently identified by the FDA, including:

a. Sterilization *surgery* for women;

b. Copper intrauterine devices;

c. Intrauterine devices (IUD) with progestin (all durations and doses), including insertion and removal;

d. Barrier methods including male and female condoms (Rx required from provider, limited to 30 per month);

e. Diaphragm with spermicide;

f. Sponge with spermicide,

g. Cervical cap with spermicide and spermicide alone;

h. Oral contraceptives including the pill (combined pill and extended/continuous use), and the mini pill (Progestin only);

i. The contraceptive patch;

j. Other hormonal contraceptives, including inserted and implanted contraceptive devices, hormone contraceptive injections; and

k. The vaginal contraceptive ring;

l. Emergency contraception (the morning after pill);

m. Emergency contraception (Levonorgestrel and Ulipristal acetate);

n. Implantable rods;

o. Prescription based sterilization procedures for women; and

p. FDA-approved tubal ligation.

Coverage is also available for:

1. Any additional contraceptives approved, granted, or cleared by the FDA (if the patient and the patient's attending provider have determined it to be medically appropriate).
2. 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).
3. 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 Expense Benefits

Habilitative Developmental Services are a *covered service* and may be subject to *prior authorization* to determine *medical necessity*. Examples include, but are not limited to, toileting, dressing, using fine motor skills, crawling, walking, categorization, expressing oneself (making wants and needs known), picture recognition, identifying letters, numbers, shapes, etc., appropriate play skills and coping mechanisms.

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

See your *Schedule of Benefits* for benefit levels or additional limits. Please note there are separate limits for developmental services provided as part of the *habilitation* benefits listed above.

High Frequency Chest Wall Oscillators

Covered expenses for a member, when determined *medically necessary*, is provided for one high frequency chest wall oscillator during such *member's* lifetime.

Home HealthCare Expense Benefits

Covered expenses for *home healthcare* are covered when your *physician* indicates you are not able to travel for appointments to a medical office. Coverage is provided for *medically necessary* network care provided at the *member's* home and are limited to the following charges:

1. *Home health aide services*;
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home healthcare* and developmental services associated with developmental delays, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder;
3. Intravenous medication and pain medication (Intravenous medication and pain medication are *covered service* expenses to the extent they would have been *covered service* expenses during an *inpatient hospital* stay);
4. Hemodialysis, and for the processing and administration of blood or blood components;
5. *Necessary medical supplies*; and
6. Rental 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.

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

Home healthcare services and benefits are subject to *prior authorization* requirements as outlined in this *policy*.

Limitations:

See your *Schedule of Benefits* for benefit levels or additional limits for expenses related to *home health aide services*. Each 8-hour period of *home health aide services* will be counted as one visit.

Exclusion:

No benefits will be payable for charges related to private duty nursing, custodial care, or educational care, under the Home Healthcare Expense Benefits provision.

Hospice Care Expense Benefits

This provision only applies to a *terminally ill member* receiving *medically necessary* care under a *hospice* care program or in a home setting. *Respite care* is covered on an *inpatient* or home basis to allow temporary relief to family members from the duties of caring for a *member* under *hospice* care. Respite days that are applied toward the *member's deductible amount* are

considered benefits provided and shall apply against any maximum benefit limit for these services. *Respite care* coverage is limited to 14 calendar days per year.

The list of *covered service* expenses includes:

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

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

Exclusions and Limitations

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

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

Hospital Benefits

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

1. Daily room and board.
    a. *Hospital* admissions are subject to pre-admission notification. Please call the number listed on your identification card to notify us of the admission.
    b. Services rendered in a *hospital* in a country outside of the United States of America shall not be paid except at our sole discretion;
    c. Admissions to a long-term acute care *hospital* or to a long-term acute care division of a *hospital* are subject to pre-admission notification.
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, that are routinely provided by the *hospital* to persons for use only while they are *inpatient*;

6. For a condition requiring that you be isolated from other patients, we will pay for an isolation unit equipped and staffed as such, including a private *hospital* room;
7. Emergency treatment of an *injury* or *illness*, even if confinement is not required. When emergency treatment is needed the *member* should seek care at the nearest facility. Emergency treatment received within 48 hours of the emergency is subject to the *deductible*, *copayment* and *coinsurance* specified in your *Schedule of Benefits*.
    a. **After-Hours Clinic or Urgent Care Center.** Services provided in an after-hours network *urgent care center* are subject to the urgent care *deductible*, *copayment* and *coinsurance* for each visit.
    b. **Observation Services**. Observation services are covered when ordered by a *physician*.
    c. **Transfer to Network Hospital**. Continuing or follow-up treatment for *injury* or emergency treatment is limited to care that meets primary coverage criteria before you can be safely *transferred*, without medically harmful or injurious consequences, to a *network hospital* in the *service area*. Services are subject to all applicable *deductible*, *copayment* and *coinsurance*.
    d. **Emergency Hospital Admissions**. You are responsible for notifying Ambetter from Arkansas Health & Wellness of an emergency admission to a *hospital* within 24 hours or the next business day. Failure to notify Ambetter from Arkansas Health & Wellness may result in the *member* paying a greater portion of the medical bill.
    e. **Medical Review of Emergency Care**. Emergency treatment is subject to medical review. If, based upon the signs and symptoms presented at the time of treatment as documented by attending health care personnel, Ambetter from Arkansas Health & Wellness determines that a visit to the emergency room fails to meet the definition of emergency treatment, coverage shall be denied, and the emergency room charges will become the *member's* responsibility.
8. Services of a social worker while *hospitalized*.

Inotropic Agents for Congestive Heart Failure

Covered expenses for infusion of inotropic agents where the *member* is on a cardiac transplant list at a *hospital* where there is an ongoing cardiac transplantation program.

Long Term Acute Care

Long-term acute care *hospitals* (LTACHs) furnish extended medical and rehabilitative care to individuals with clinically complex problems, such as multiple acute or chronic conditions, that need hospital-level care for relatively extended periods.

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

1. Complex wound care:
    a. Daily *physician* monitoring of wound
    b. Wound requiring frequent complicated dressing changes, and possible repeated debridement of necrotic tissue

c. Large wound with possible delayed closure, draining, and/or tunneling or high output fistulas

d. Lower extremity wound with severe ischemia

e. Skin flaps and grafts requiring frequent monitoring

2. Infectious disease:

a. Parenteral anti-infective agent(s) with adjustments in dose

b. Intensive sepsis management

c. Common conditions include osteomyelitis, cellulitis, bacteremia, endocarditis, peritonitis, meningitis/encephalitis, abscess and wound infections

3. Medical complexity:

a. Primary condition and at least two other actively treated co-morbid conditions that require monitoring and treatment

b. Common conditions include metabolic disorders, stroke, heart failure, renal insufficiency, necrotizing pancreatitis, emphysema (COPD), peripheral vascular disease, and malignant/end-stage disease

4. Rehabilitation:

a. Care needs cannot be met in a rehabilitation or *skilled nursing facility*

b. Patient has a comorbidity requiring acute care

c. Patient is able to participate in a goal-oriented rehabilitation plan of care

d. Common conditions include CNS conditions with functional limitations, debilitation, amputation, cardiac disease, orthopedic *surgery*

5. Mechanical ventilator support:

a. Failed weaning attempts at an acute care facility

b. Patient has received mechanical ventilation for 21 consecutive days for 6 hours or more/per day

c. Ventilator management required at least every 4 hours as well as appropriate diagnostic services and assessments

d. Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions

e. Patient is hemodynamically stable and not dependent on vasopressors

f. Respiratory status is stable with maximum PEEP requirement 10 cm H2O, and FiO2 60% or less with O2 saturation at least 90%

g. Common conditions include complications of acute lung *injury*, disorders of the central nervous and neuromuscular systems, and cardiovascular, respiratory, and pleural/chest wall disorders

h. Patient continues to meet the criteria above and does not meet the criteria to be transitioned to alternate level of care.

LTACH benefits are subject to *prior authorization* requirements as outlined in this *policy*.

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.

Maternity Care

Coverage for maternity care: outpatient and *inpatient* pre- and post-partum care including examinations, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other *medically necessary* reasons, less any applicable *deductible amount*, *copayment amount* or *coinsurance*.

Covered services also include hepatitis C screening during *pregnancy* by a *healthcare professional*, and such screening is not subject to *deductible* or *copayment* requirements. An *inpatient* stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a cesarean delivery. We do not require a *physician* or other healthcare provider to 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 *prior authorization*.

Covered services also include a screening for depression for the mother within the first six weeks of giving birth by a *physician* or licensed *healthcare professional* who is attending a birth or providing medical treatment to the mother. If the mother declines the screening within the first six weeks of giving birth, the *physician* or licensed healthcare provider will update the *member's* medical records that the *member* refused the screening for depression.

Covered services include breastfeeding and lactation consultant services, and are not subject to an annual *deductible, copayment* or *coinsurance* limits.

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

1. Outpatient and *inpatient* pre- and post-partum care, including examinations, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment and childbirth classes;
2. *Physician* home visits and office services;
3. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests;
4. Complications of *pregnancy*;
5. *Hospital* stays for other *medically necessary* reasons associated with maternity care;
6. Home births performed by a licensed/certified midwife or other *healthcare professional*, when the service is covered under this policy and acting with the scope of applicable licensure or certification;
7. *Covered services* rendered by a certified community-based doula performing services within the scope of that certification; and

8. Birthing services received in a birthing center licensed by the Arkansas Department of Health. Coverage for birthing services received in a licensed birthing center will be provided on the same basis as coverage for birthing services received in a hospital and will not be subject to a greater deductible, copayment, coinsurance, or out-of-pocket limit than any other covered benefit.

Duty to Cooperate
We do not cover services or supplies related to a *member's pregnancy* when a *member* is acting as a *surrogate* and has entered into a *surrogacy arrangement*. For more information on excluded services, please see the **General Limitations 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/ar and send to:

Ambetter from Arkansas Health & Wellness
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 *policy*, plus interest, attorneys' fees, costs and all other remedies available to us.

Medical and Surgical Expense Benefits

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

1. For *surgery* in a *physician*'s office, *inpatient* facility, outpatient facility, or a surgical facility, including services and supplies;
2. Made by an assistant surgeon;
3. For pre-surgical and post-surgical procedural 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; and
    b. The tests must be for the same bodily *injury* or *illness* causing the *member* to be hospital confined or to have the outpatient *surgery* or procedure.
    c. Sleep disorder studies in home or facility;
    d. Bone density studies;
    e. Clinical laboratory tests;

f. Gastrointestinal lab procedures;

g. Pulmonary function tests;

h. Genetic testing;

4. For *medically necessary* genetic testing.
5. Family planning for certain professional provider contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices, to the extent such services and supplies are legal under *applicable law*.
6. 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;
7. For chemotherapy (including oral chemotherapy), inhalation therapy, infusion therapy, and radiation therapy or treatment in a *hospital*, or office setting;
8. 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), Medical and Surgical Supplies, Orthotic devices** and **Prosthetics** provision of this *policy*;
9. 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;
10. For the cost and administration of an anesthesia, oxygen, drugs, medications, and biologicals;
11. For *medically necessary* reconstructive or cosmetic *surgery* including, but not limited to:

    a. For reconstructive breast *surgery* charges as a result of a partial or total mastectomy. *Prior authorization* is required. Coverage includes:

    b. All stages of *surgery* and reconstruction of the breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemaFor *medically necessary* dental *surgery* due to:

    c. An accidental *injury*, which results in damage to his or her natural teeth. *Injury* to the natural teeth will not include any *injury* as a result of chewing;

    d. *Surgery* to correct a functional defect which results from a congenital and/or acquired disease or anomaly;

    e. Cleft lip and cleft palate for an eligible *member*. *Covered services* includes 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;

    f. 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 health care professional, 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 individual 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* by us. Please call Member Services to confirm your benefits for the use of general anesthesia in a *hospital* or *ambulatory surgical center*.

12. For infertility counseling and planning services when provided by a *network provider* and testing to diagnose infertility;
13. For the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants;
14. 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 the contract. See Clinical Trial Coverage provision of this *policy*;
15. 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
16. For X-ray, Magnetic Resonance Imaging (MRI), Computer Tomography (CT scan), *Positron emission tomography*/Single Photon Emission Computed Tomography (PET/SPECT), and other diagnostic services. See Radiology, Imaging and Other Diagnostic Testing provision of this *policy*;
17. For *medically necessary telehealth services* subject to the same clinical and *utilization review* criteria, plan requirements and limitations as the same health care services when delivered to a *member* in-person;
18. For *surgery* or services related to cochlear implants and bone anchored hearing aids. See your *Schedule of Benefits* for additional information;
19. For *medically necessary* services for complications arising from medical and surgical conditions;

20. For respiratory, pulmonary, cardiac, physical, occupational, and speech therapy services. Please see Rehabilitation Expense Benefits & Habilitation Expense Benefits provisions of this *policy*;
21. For maternity care services including but not limited to prenatal, postnatal, diagnostic testing, laboratory services, and *hospital* services;
22. 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;
23. For *medically necessary* routine foot care and foot care treatment that may require *surgery*; *prior authorization* may be required;
24. 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*;
25. For *medically necessary* biofeedback services;
26. For services associated with human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation or transplant procedure;
27. For *medically necessary chiropractic care* or manipulative therapy treatment on an outpatient basis only. See your *Schedule of Benefits* for benefit levels or additional limits. *Covered services* are subject to all other terms and conditions of the *policy*, including the *deductible amount* and *cost sharing* provisions;
28. 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 exams, and pulse oximetry;
29. For *medically necessary* allergy testing and treatment including allergy injections and serum;
30. For services of standby *physicians* are only covered in the event such *physician* is required to assist with certain high-risk services specified by Ambetter from Arkansas Health & Wellness, and only for such time as such *physician* is in immediate proximity to the patient;
31. For electronic consultations between a *medical practitioner*, with other involved *medical practitioners*. Benefits include telephone calls or other forms of electronic consultations between a *medical practitioner* and a *member*, or between a *medical practitioner* and another *medical practitioner*;
32. For coverage for gastric pacemakers for members diagnosed with gastroparesis, eligible charges and limits are based on *medical necessity* and require prior authorization;
33. Hearing Aids (see your *Schedule of Benefits* for additional information);
34. For one auditory brain stem implant for a *member*, when determined *medically necessary*;
35. For implantable osseointegrated hearing aid for members with single-sided deafness and normal hearing in the other ear. Coverage is further limited to members with:

a. Congenital or surgically induced malformations (e.g., atresia) of the external ear canal or middle ear;

b. Chronic external otitis or otitis media, subject to prior authorization;

c. Tumors of the external canal or tympanic cavity; and

d. Sudden, permanent, unilateral hearing *loss* due to trauma, idiopathic sudden hearing *loss*, or auditory nerve tumor;

36. For testing and evaluation:

a. Psychological testing, including but not limited to, assessment of personality, emotionality and intellectual abilities;

b. Childhood developmental testing, including but not limited to assessment of motor, language, social, adaptive or cognitive function by standardized developmental instruments;

c. Neurobehavioral status examination, including, but not limited to assessment of thinking, reasoning and judgment;

d. Neuropsychological testing, including, but not limited to Halstead-Reitan, Luria and WAISR;

37. For *medically necessary* services made by a *physician* who renders services in a *network urgent care center*, including facility costs and supplies;

38. For new intervention (one that is not commonly recognized as a generally accepted standard of medical practice) when it is shown through scientific evidence that the intervention will achieve its intended purpose and will prevent, cure, alleviate or enable diagnosis or detection of a medical condition without exposing the *member* to risks that outweigh the potential benefits. New interventions in the process of phase I, II or III trials are not covered;

39. For oral *surgery* (non-dental related only) is covered for:

a. Tumors/cysts (excision when attached to the jaws, cheeks, lips, tongue, roof or floor of mouth when a pathological examination is required);

b. Exostoses (excision of jaws and hard palate);

c. Cellulitis (external incision and a drainage); and

d. Sinuses, salivary glands or ducts (incision of accessory sinuses, salivary glands or ducts);

40. For *reconstructive surgery* performed for the correction of a cleft palate, cleft lip, removal of a port-wine stain, hemangioma (only on the face), or for the correction of a congenital abnormality;

41. For abortions performed to save the life of the member and performed in accordance with *applicable law*;

42. For elective sterilization procedures (e.g., vasectomies). **Note**: No *cost-share* applies, except for HSA-compatible plans;

43. For a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non-infectious, and (2) For one pair of eyeglasses or contact lenses per *member* following a covered cataract surgery;
44. For the cost of a monofocal lens, if the multifocal lens is implanted after a cataract extraction;
45. Complications resulting from the smallpox vaccine;
46. For infusion therapy.
47. For *medically necessary covered services* provided in a mobile unit, when the same service is otherwise covered under this *policy* in another place of service. *Cost sharing* for *covered services* provided in a mobile unit will be no less favorable than the *cost sharing* for *covered services* provided in a different place of service.
48. For *covered services* rendered by a *certified community health worker* performing services within the scope of that certification.
49. For expenses or services related to immunizations and vaccinations for travel purposes.
50. 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 Foods

We cover *medical foods* and formulas for:

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

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

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

Low Protein Modified Food Products

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. *Covered expenses* shall include *medically necessary medical foods* (food products and formulas) for the therapeutic treatment of a *member* inflicted with an inherited metabolic disorder involving a failure to properly metabolize certain nutrients. The *medical foods* must be prescribed by a licensed healthcare provider.

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
9. Nitrogen metabolism disorder
10. Homocystinuria
11. Citrullinemia
12. Argininosuccinic acidemia
13. Very-long-chain acyl-CoA dehydrogenase deficiency
14. Long-chain 3-hydroxyacyl-CoA dehydrogenase deficiency
15. Trifunctional protein deficiency
16. 3-methylcrotonyl CoA carboxylase deficiency

17. Methlmalonic acidemia due to cobalamin A,B defect
18. Ornithine transcarbamylase deficiency
19. Non-ketotic hyperglycinemia
20. Glycogen storage diseases
21. Disorders of creatine metabolism
22. Malonic aciduria
23. Carnitine palmitoyl transferase deficiency type II
24. Glutaric aciduria type II
25. Sulfite oxidase deficiency

Exclusions

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

Medical Dental Services

Anesthesia and hospital charges for *medically necessary* dental care are covered if the *member* requires dental treatment to be given in a hospital or outpatient *ambulatory surgical center*. The indications for general anesthesia, as published in anesthesia and sedation reference manuals of the American Academy of Pediatric Dentistry and American Dental Association, should be used to determine whether performing dental procedures is necessary to treat the *member's* condition under general anesthesia.

Coverage is 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 in order to create a more normal appearance.

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

2. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* or office charges for dental care, rendered by a dentist, regardless of whether the services are provided in a *network hospital*, surgical center or office, provided to the following *members*:
   a. A *member* who is determined by two (2) dentists to require without delay necessary dental treatment in a *hospital* or *ambulatory surgical center* for a significantly complex dental condition; or
   b. A person who has a diagnosed serious mental or physical condition; or
   c. A person with a significant behavioral problem (as certified by the *member's physician*).
3. 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 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 for evaluation and diagnosis of refractive error, including presbyopia.
2. Visual therapy.
3. Any vision services, treatment or material not specifically listed as a covered service.
4. Low vision services and hardware for adults.
5. Radial keratotomy, LASIK, and other refractive eye surgery.
6. Services or materials provided because of any workers' compensation law or required by any governmental agency.
7. Orthoptics, vision training, or subnormal vision aids.
8. Non-network care, except when *prior authorized*.

Reading glasses for children may be furnished based on the merits of the individual case. The doctor should indicate why such corrections are necessary. All such requests will be reviewed on a *prior authorization* basis.

Mental Health and Substance Use Disorder Benefits

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

Deductible amounts, *copayment* or *coinsurance amounts* and treatment limits for covered *behavioral health* benefits will be provided on the same terms and conditions as medical and surgical benefits.

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

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

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

Inpatient

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

Outpatient

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

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

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

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

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

We oversee the delivery and oversight of covered *behavioral health* services for Ambetter from Arkansas Health & Wellness. If you need mental health or *substance use disorder* treatment, you may choose any provider participating in our *behavioral health* provider network and do not need a referral from your *PCP* in order to initiate treatment. You can search for network *behavioral health* providers by accessing the "Find a Doctor" page at AmbetterHealth.com/en/ar or by calling Member Services.

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

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

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

Neurological Rehabilitation Facility Services

Covered expenses for *neurologic Rehabilitation Facility* services are limited to:

1. The *member* must be suffering from *severe traumatic brain injury*;
2. The admission must be within seven calendar days of release from a *hospital*;
3. *Prior authorization* must be given with written *authorization* of the admission to the *neurologic rehabilitation facility* prior to the *member* receiving *neurologic rehabilitation facility* services; and

4. The *neurologic rehabilitation facility* services are of a temporary nature with a potential to increase ability to function.

Exclusions and Limitations

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

1. Custodial care;
2. Nursing home or Assisted Living Facilities; and
3. Coverage exceeding the maximum day limit, as addressed in your *Schedule of Benefits*.

Newborns' and Mothers' Health Protection Act Statement of Rights

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

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

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

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

Pediatric Vision Benefits – Children under the age of 19

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

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. Eye glass repair if glasses were originally covered under this *policy*.
6. Replacement of lost or broken glasses, only one time within a year.
7. Contact lens allowance (includes contact lens fitting).
8. Low vision evaluation/aids.
9. Eyeglasses for children diagnosed as having the following diagnoses must have a surgical evaluation in conjunction with supplying eyeglasses:
   a. Ptosis (droopy lid)
   b. Congenital cataracts
   c. Exotropia or vertical tropia
   d. Children between the ages of 12 and 21 exhibiting exotropia
10. Vision therapy developmental testing
    a. Orthoptic and pleoptic training with continuing medical direction and evaluation;
    b. Sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure;

c. Developmental testing extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report.

11. Eye prosthesis and polishing services

Please refer to your *Schedule of Benefits* for a detailed list of *member* cost sharing, annual *maximum out-of-pocket* amounts. To see which vision providers are part of the *network*, please visit AmbetterHealth.com/en/ar 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 expenses in this benefit provision are limited to charges from a licensed pharmacy for:

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

Such *covered services* shall include those for prescribed, orally administered anticancer medications. The *covered service* shall be no less favorable than for intravenously administered or injected cancer medications that are covered as medical benefits under this *policy*. The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her *physician*.

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.

Covered expenses shall include coverage for prescribed drugs or devices approved by the FDA for use as a contraceptive.

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

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.

Notice and Proof of Loss

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

Lock-in Program

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

Exclusions and Limitations:

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

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance, unless listed on the formulary;
2. For immunization agents otherwise not required under the Affordable Care Act;
3. For medication that is to be taken by the *member*, in whole or in part, at the place where it is dispensed;
4. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals;
5. For a refill dispensed more than 12 months from the date of a *physician's* order;
6. For more than the predetermined managed drug limitations assigned to certain drugs or classification of drugs;
7. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are listed on the formulary. This exclusion does not apply to prescribed FDA approved contraceptive methods;

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

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.

Diabetic Care Expenses

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 your *prescription drug* benefits. *Prescription drug cost sharing* applies.

How to Fill a Prescription

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

If you decide to have your *prescription order* filled at a network pharmacy, you can use the Provider Directory to find a pharmacy near you. You can access the Provider Directory at AmbetterHealth.com/en/ar 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.

Extended Days' Supply

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/ar. You can also request to have a copy mailed directly to you.

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.

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.

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 Ambetter website, you will find details on your in-network mail order pharmacies and next steps for enrollment.

Formulary or Prescription Drug List

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

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

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

Non-Formulary Prescription Drugs

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

Cost sharing paid on your behalf for any *prescription drugs* with a generic equivalent will not apply toward your plan *deductible* or your *maximum out-of-pocket amount* if a *drug discount, coupon, copayment card, or manufacturer supplied prepaid credit card* was used.

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.

Step Therapy for Prescription Drugs

Our *policy* uses a requirement of step therapy for certain *prescription drugs*. We employ clinical pharmacists who review, research and analyze the efficacy and value of various drugs. Based on their reviews of clinical practice guidelines and recommended treatment of diseases, they recommend specific drugs as the first ones to try when a *member* begins or requires a

change in medication therapy. For most people, these medications work well. In the limited instances where one of these medications is not effective and/or appropriate for a particular member, the prescribing *physician* contacts us about approving coverage for a different medication. Trying medications in this "step-by-step" fashion is called step therapy. This also ensures that drugs are used in the appropriate clinical order for your medical condition.

Prescription Drug Exception Process

Standard exception request

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

If a response by us is not received within the time allotted under this section, the request for a step therapy protocol exception shall be deemed granted. In addition, if a request for a step therapy protocol exception is incomplete or additional clinically relevant information is required, we shall notify the prescribing healthcare provider within 72 hours of submission of standard request, of the additional clinical information required to approve or deny. Once the requested information is submitted, a step therapy protocol exception request shall be determined within 72 hours for standard exception requests.

If a *prior authorization* request is denied because of a step therapy requirement, then the *utilization review* entity must authorize the preferred treatment required under step-therapy if a *prior authorization* for the preferred treatment is required without requiring the provider to submit a new or revised request.

Expedited exception request

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

If a response by us is not received within the time allotted under this section, the request for a step therapy protocol exception shall be deemed granted. In addition, if a request for a step therapy protocol exception is incomplete or additional clinically relevant information is required, we shall notify the prescribing healthcare provider within 24 hours of submission of expedited request, of the additional clinical information required to approve or deny. Once the requested

information is submitted, a step therapy protocol exception request shall be determined within 24 hours for expedited exception requests.

If a *prior authorization* request is denied because of a step therapy requirement, then the *utilization review* entity must authorize the preferred treatment required under step-therapy if a prior authorization for the preferred treatment is required without requiring the provider to submit a new or revised request.

External exception request review

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

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

Preventive Care Expense Benefits

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

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

Preventive care benefits obtained from a *network provider* are covered without *member cost share* (i.e., covered in full without *deductible*, *coinsurance amount* or *copayment amount*). For HSA-compatible plans, the *deductible* cannot be waived for benefits that exceed the federal ACA preventive care requirements. For current information regarding available preventive care benefits, please access the federal government's website at: https://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.

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

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

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

Notification

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

Prostate Screening and Prostate Specific Antigen Testing

Medically necessary covered services include an prostate cancer screenings, including a digital rectal examination and prostate specific antigen test performed to determine the level of prostate specific antigen in the blood, when included in guidelines published by the National Comprehensive Cancer Network as of January 1, 2009 and 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* (including, X-ray, Magnetic Resonance Imaging (MRI), Computed Tomography (CT scan), *Positron emission tomography* (PET/SPECT), and ultrasound). *Prior authorization* may be required, see your *Schedule of Benefits* for details. **NOTE**: Depending on the service performed, two bills may be incurred – both subject to any applicable *cost sharing* – one for the technical component (the procedure itself) and another for the professional

component (the reading/interpretation of the results by a *physician* or other qualified practitioner).

*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.

Rehabilitation Expense Benefits

Covered expenses include expenses incurred for *rehabilitation* services, subject to the following limitations:

1. *Covered expenses* available to a *member* while confined primarily to receive *rehabilitation* are limited to those specified in this provision;
2. Rehabilitation services or confinement in a *rehabilitation facility* must be determined *medically necessary*;
3. *Covered expenses* for *provider facility* services are limited to charges made by a *hospital* or *rehabilitation facility* for:
    a. Daily room and board and nursing services;
    b. Diagnostic testing; and
    c. Drugs and medicines that are prescribed by a *physician*, filled by a licensed pharmacist and approved by the FDA.
4. *Covered expenses* for non-provider facility services are limited to charges incurred for the professional services of rehabilitation licensed practitioners;
5. Outpatient physical therapy, occupational therapy, speech therapy, pulmonary and aural therapy for rehabilitative purposes;
6. *Inpatient* physical therapy, occupational therapy, speech therapy, pulmonary and aural therapy for rehabilitative purposes; and
7. Coverage includes cardiac and pulmonary *rehabilitation*.

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; and
4. Care is primarily custodial care.

Second Medical Opinion

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

1. Whenever a minor *surgical procedure* is recommended to confirm the need for the procedure;

2. Whenever a serious *injury* or *illness* exists; or
3. Whenever you find that you are not responding to the current treatment plan in a satisfactory manner.

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

Skilled Nursing Facility Expense Benefits

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

1. *Covered expenses* for *provider facility* services are limited to charges made by a *hospital* or *skilled nursing facility* for:
   a. Daily room and board and nursing services;
   b. Diagnostic testing; and
   c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the FDA.

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

Sleep Studies

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

Temporomandibular Joint Disorder and Craniomandibular Disorder Expense Benefits

Covered service expenses expanded to include the charges incurred for diagnosis and treatment services, both surgical and nonsurgical for temporomandibular joint (TMJ) disorder and craniomandibular disorder. These expenses shall be the same as that for treatment to any other joint in the body. Coverage shall apply if the treatment is administered or prescribed by a *physician* or dentist.

Transplant Services

Covered expenses 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 policy. *Prior authorization* must be obtained through the "Center of Excellence," a *network* facility, or in a *non-network* facility approved by us when there is no *network* adequacy, before an evaluation for a transplant. We may require additional information such as testing and/or treatment before determining *medical necessity* for the transplant benefit. *Authorization* must be obtained prior to performing any related services to

the transplant *surgery*. Transplant services must meet medical criteria as set by Medical Management Policy.

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

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

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

1. Pre-transplant evaluation;
2. Pre-transplant harvesting;
3. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant);
4. 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 participating facility;
7. Post-transplant follow-up visits and treatments;
8. Donor testing if the donor is found compatible;
9. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors; and
10. All costs incurred and medical expenses by the donor shall be paid under the transplant recipient policy, this excludes travel, lodging, food, and mileage.

Please refer to the "Member Transplant Travel Reimbursement Policy" for outlined details on reimbursement limitations (https://www.ambetterhealth.com/en/ar/resources/handbooks-forms/).

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

Ancillary "Center of Excellence" Service Benefits:

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

1. We will pay for the following services when the *member* is required to travel more than 60 miles from the *residence* to the Center of Excellence:
2. We will pay a maximum of $10,000 per transplant service for the following services:
    a. Transportation for the covered person, any live donor, and the companion(s) to accompany the *member* to and from the Center of Excellence, in the United States.
    b. When a *member* 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 home to the transplant facility, and to and from the donor's home 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.

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

Non-Covered Services and Exclusions

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

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *medically necessary* transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the Center of Excellence.
4. To keep a donor alive for the transplant operation, except when *authorized* through the Center of Excellence.
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
6. Related to transplants unauthorized through the *Center of Excellence* and is not included under this provision as a transplant.

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

Trans-telephonic Home Spirometry

Coverage for *eligible expenses* for trans-telephonic home or ambulatory spirometry for members who have had a lung transplant.

Urgent Care Service Benefits

Urgent care services include *medically necessary* services by *network providers* 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. Please refer to your *Schedule of Benefits* for the *cost sharing* applicable to urgent care services. Please note: 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 1-877-617-0390 (TTY 1-877-617-0392). The 24/7 Nurse Advice Line is available 24 hours a day, seven days a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

WELLNESS PROGRAMS AND OTHER OFFERINGS

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

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

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

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

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

GENERAL LIMITATIONS AND EXCLUSIONS

No benefits will be paid for:

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

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*;
2. For any portion of the charges that are in excess of the *eligible expense*;
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery, bariatric surgery;
4. For weight loss programs, gym memberships, exercise equipment or meal preparation programs;
5. For the reversal of sterilization and the reversal of vasectomies;
6. For abortions unless performed to save the life of the *member* and not illegal under *applicable law*;
7. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered expenses* of the Medical Benefits provision;
8. For expenses for television, telephone, or expenses for other persons;
9. For telephone consultations between providers, 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 expenses*, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under **Major Medical Expense Benefits** section;
12. For cosmetic treatment, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect as described in the Medical and Surgical Expense Benefits provision under the **Major Medical Expense Benefits** section;
13. For mental health examinations and services involving:
    a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody, disability, or fitness for duty/return to work, unless a *network physician* determines such evaluation to be *medically necessary*;
    b. When ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless a network *physician* determines such services to be *medically necessary*; and
    c. Testing of aptitude, ability, intelligence or interest;
14. For services which are custodial in nature. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Expense Benefits;
15. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism;
16. While confined primarily to receive *rehabilitation*, custodial care, educational care, or nursing services, unless expressly provided for by the *policy*;
17. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*;
18. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the *policy*;
19. 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;
20. For *experimental or investigational* treatment(s) or *unproven services*. The fact that an *experimental or investigational* treatment or unproven service is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational* treatment or unproven service for the treatment of that particular condition;
21. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's* workers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency;

22. For a surrogacy *arrangement*. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or using the services of a *surrogate* who may or may not be a *member* including, but not limited to:

    a. Prenatal care;

    b. Intrapartum care (or care provided during delivery and childbirth);

    c. Postpartum care (or care for the *surrogate* following childbirth);

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

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

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

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

    h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement*; including but not limited to labs, imaging, and diagnostics.

    i. Any complications of the surrogate resulting from the pregnancy;

    j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*;

    k. Pre-counseling, advice on procreation, or consultations related to gestational carriers or donor services;

    l. Any corrective surgeries or laparoscopic procedures for the sole purpose of *surrogacy arrangement*; or

    m. Any other medical or healthcare services related to the pregnancy or preparations to become a *surrogate* or donor.

Any and all other health care services, supplies or medication provided to any child birthed by a surrogate as a result of a *surrogacy arrangement* are also excluded, except when the child has an active *policy* with us effective at the time of birth;

23. For fetal reduction *surgery*;

24. For 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, except as specifically identified as a *covered expense* under the *policy*;

25. 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;

26. 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;
27. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of the *member's* enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date;
28. For the following miscellaneous items: artificial insemination except where required by federal or state law; biofeedback; care or complications resulting from non-*covered expenses*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the **Medical Foods** provision; health club memberships, unless otherwise covered; home test kits, unless required by *applicable law*; care or services provided to a non-member biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; private duty nursing; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service area; treatment of spider veins; transportation expenses; unless specifically described in this *policy*;
29. For diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment. Benefits will be allowed for services that would otherwise be covered under this *policy*;
30. For take-home dressings and supplies following hospitalization; any other supplies, dressings, appliances, devices or services which are not specifically listed as covered above; replacement or repair of appliances, devices and supplies due to *loss*, breakage from willful damage, neglect or wrongful use, or due to personal preference;
31. For services or supplies eligible for payment under either federal or state programs (except Medicaid). This exclusion applies whether or not you assert your rights to obtain this coverage or payment of these services;
32. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status. To facilitate appropriate benefit use and prevent opioid overutilization, *member's* participation in lock-in status will be determined by review of pharmacy claims;
33. For any medicinal and recreational use of cannabis or marijuana;
34. For expenses or services related to immunizations and vaccinations for occupational purposes, unless otherwise covered under this *policy*;
35. For expenses or services related to massage therapist;
36. With the exception of certain services to diagnose infertility, which are limited as set forth in this policy, we will not cover any diagnosis, treatments, surgeries, procedures, medications, or any other services related to infertility;
37. 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;
38. For expenses, services, and treatments from a Naturopathic specialist for treatment of prevention, self-healing and use of natural therapies;

39. For expenses for services related to dry needling;
40. For expenses or services related to private duty nursing services;
41. For Assertive Community Treatment (ACT).
42. 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.

Out-of-area providers: Except for *dependent members* living outside the *service area*, benefits are not available for non-emergency services received from a *non-network provider* located outside of the *service area.*

TERMINATION

Termination of Policy

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

1. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *policy* (including, but not limited to, the Grace Period provision) or the date that we have not received timely premium payments in accordance with the terms of this *policy*;
2. The date we receive a request from you to terminate this *policy*, or any later date stated in your request, or if you are enrolled through Health Insurance Marketplace, the date of termination that the Health Insurance Marketplace provides us upon your request of cancellation to the Health Insurance Marketplace;
3. The date we decline to renew this *policy*, as stated in the Discontinuance provision;
4. The date of your death, if this *policy* is an individual plan;
5. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact;
6. The date a *member's* eligibility for insurance under this *policy* ceases due to any of the reasons stated in the **Eligibility and Enrollment** section in this *policy*; or
7. For an *eligible child* reaching the limiting age of 26, coverage under this *policy* for an *eligible child* will terminate at 11:59 p.m. on the last day of the year in which the *eligible child* reaches the limiting age of 26.

Refund upon Cancellation

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

Discontinuance

90-Day Notice:

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

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

SUBROGATION AND RIGHT OF REIMBURSEMENT

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

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

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

1. Payments made by a *third-party* or any insurance company on behalf of the *third-party*;
2. Any payments or awards under an uninsured or underinsured motorist coverage policy;
3. Any workers' compensation or disability award or settlement;
4. Medical payments coverage and no fault coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and
5. Any other payments from a source intended to compensate a *member* for *third-party injuries*.

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

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

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

1. To fully cooperate with us in order to obtain information about the *loss* and its cause;

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

Our right of subrogation and reimbursement only exists to the extent the *member* has been made whole. Any costs associated with subrogation shall be shared in the same proportion as each participant shared in the recovery amount.

COORDINATION OF BENEFITS

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

This plan is subject to Medicaid's *third-party* liability rules, and will only pay for *covered services* when all other sources of coverage have been exhausted. This plan pays secondary to all other *plans*.

It is a contractual provision of a majority of health benefit contracts. We comply with state regulations for COB.

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

"Allowable expense", except as set forth below or where a statute requires a different definition, means any health care expense, including *coinsurance* or *copayments* and without reduction for any applicable *deductible*, that is covered in full or in part under any of the plans covering the person. "Plan", as used in this section, is a form of coverage with which coordination is allowed.

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

An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.

Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a *member* is not an allowable expense.

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

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

4. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefits or services for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

The term "Plan" includes:

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

The term "Plan" does not include:

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

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

1. The plan has no order of benefit rules or its rules differ from those required by regulation; or

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

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

Order of Benefit Determination Rules

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

1. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. A plan may consider benefits paid or provided by another plan in determining its benefits only when it is secondary to that *other plan*.
2. If the *other plan* does not contain a coordination of benefits provision that is consistent with this provision, that plan is always primary, unless the coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that the supplementary coverage shall be excess to any other parts of the plan provided by the *policy* holder.
3. Each plan determines its order of benefits using the first of the following rules that apply:
    a. Non-Dependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, *subscriber* or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, *subscriber* or retiree is the secondary plan and the *other plan* is the primary plan.
    b. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:
        i. If a child is covered under the plans of both parents and the parents are living together, whether or not they have ever been married, the plan of the parent whose birthday falls earlier in the *calendar year* (excluding year of birth) shall be primary. If both parents have the same birthday, the plan that covered the parent longer will be primary.
        ii. If a child is covered by both parents' plans, the parents are separated or divorced or are not living together, whether or not they have ever been married:

A. If a court order or decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's *spouse* does, that parent's *spouse*'s plan is the primary plan. This rule applies to the plan years commencing after the plan is given notice of the court decree;

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

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

I. The plan covering the custodial parent;

II. The plan covering the *spouse* of the custodial parent;

III. The plan covering the non-custodial parent; and then

IV. The plan covering the *spouse* of the non-custodial parent.

iii. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of subparagraphs (i) or (ii) above shall determine the order of benefits as if those individuals were the parents of the child.

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

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

6. Longer or Shorter Length of Coverage. The plan that covered the person for the longer period of time is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

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

Effects of Coordination

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

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

Right to Receive and Release Needed Information

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

Right of Recovery

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

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

CLAIMS

Notice of Claim

We must receive notice of claim within 30 calendar days of the date the *loss* began or as soon as reasonably possible. Notice given by or on behalf of the *member* to Ambetter from Arkansas Health & Wellness, Attn.: Claims Department, P.O. Box 5010, Farmington, MO 63640-5010, with information sufficient to identify the member, shall be deemed notice to us.

Claim Forms

Upon receipt of a notice of claim, we will furnish you with forms for filing *proofs of loss*. If we do not provide you with such forms within 15 calendar days after you have given us notice, you shall be deemed to have complied with the requirements of this *policy* as to *proof of loss* upon submitting, within the time required for filing proofs of *loss*, written proof covering the occurrence, the character, and the extent of the *loss* for which claim is made.

Proof of Loss

We must receive written *proof of loss* within 180 calendar days of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than one year after the date of loss will not be accepted, unless you or your covered *dependent member* had no legal capacity to submit such proof during that year.

How to Submit a Claim

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

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

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

Send all the documentation to us at the following address:

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

Cooperation Provision

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

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

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

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

Time for Payment of Claims

Benefits will be paid within 30 calendar days after receipt of *proof of loss*. Should we determine that additional supporting documentation is required to establish responsibility of payment, we shall pay benefits within 30 calendar days after receipt of additional supporting documentation.

We will pay or deny a clean claim within 30 calendar days of receipt if the claim was submitted electronically or within 45 calendar days after receipt if the claim was submitted by other means for services that do not fall under the federal No Surprises Act *balance billing protections*. For services that fall under the federal No Surprises Act *balance billing protections*, we will pay or deny a clean claim within 30 calendar days of receipt regardless of how the claim was submitted. We will pay 12 percent interest after the 61st day of nonpayment.

Payment of Claims

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

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

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

Claims Incurred for Emergency Services While Traveling Outside the United States

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

Claims incurred outside of the United States for *emergency services* must be submitted in within 180 calendar days form 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/ar.

Reimbursement for covered *emergency services* (less the *member's cost share* responsibility) will be sent to the *member*, who is responsible for paying the provider. Such payment will fulfill our obligation to the *member* for the *emergency services*. Reimbursement is based on the *member's* benefit plan, *cost share,* and currency exchange rate at the time of the transaction. The *Explanation of Benefits* will detail the *member's* responsibility and any eligible reimbursement.

Assignment

We will reimburse a *hospital* or healthcare provider to whom you have assigned your rights to receive reimbursement under this *policy* if the *hospital* or healthcare provider provides us notice of the assignment with a claim for payment for health care services and if the hospital or healthcare provider is a *non-network provider*, the notice is accompanied by a complete copy of the assignment with your signature and date.

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

No Third-party Beneficiaries

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

Medicaid Reimbursement

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

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

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

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

Insurance With Medicare

If a person is also a Medicare beneficiary, benefits will be coordinated in compliance with federal law.

Custodial Parent

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

Upon request by the custodial parent, we will:

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

A custodial parent may assign claim payments to the *hospital* or *medical practitioner* providing treatment to an *eligible child*, subject to the limitations on assignments discussed above.

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.

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

APPEAL, GRIEVANCE AND EXTERNAL REVIEW PROCEDURES

OVERVIEW

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

Call Member Services

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

Appeal

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

Filing an Appeal

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

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

Ambetter from Arkansas Health & Wellness
Attn: Appeals and Grievances Department
P.O. Box 10341
Van Nuys, CA 91410
Fax: 1-833-886-7956
Phone: 1-877-617-0390 (TTY 1-877-617-0392)

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

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

Processing your Appeal

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

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

Ambetter from Arkansas Health and Wellness will make the decision within the following timeframes of receipt of your *appeal*:

1. 72 hours after receiving your request when you are appealing the denial of a service for *urgent care*. (If your *appeal* concerns *urgent care*, you may be able to have the internal *appeal* and external reviews take place at the same time.)
2. Two business days for urgent requests and four business days for nonurgent pre-service requests regarding care for a hematology diagnosis, oncology diagnosis, or additional disease or other diagnosis that the Insurance Commissioner may include by rule.
3. 30 calendar days for appeals of denials of non-urgent care you have not yet received (pre-service).
4. 60 calendar days for appeals of denials of services you have already received (post-service denials).

We will notify you or, if applicable, your *authorized representative* in writing within two business days of the decision.

The notice will include an explanation of our decision, a reference to the criteria on which the decision was based, a list of the title and qualification of each person participating in the review, and a description of your further *appeal* rights, including the right to an external review.

Urgent Pre-Service Appeal

If your appeal for benefits is urgent, you or your authorized representative, or your healthcare provider (physician) may contact us with the appeal, orally or in writing.

If the *appeal* for benefits is one involving urgent care, we will notify you of our decision as soon as possible, but no later than 72 hours after we receive your *appeal* provided you have given us sufficient information to make a decision.

If you have not given us sufficient information, we will contact you as soon as possible but no more than 24 hours after we receive your *appeal* to let you know the specific information we will need to make a decision. You must give us the specific information requested as soon as you can but no later than 48 hours after we have asked you for the information.

We will notify you, or if applicable, your *authorized representative* of our decision as soon as possible but no later than 48 hours after we have received the needed information or at the end of the 48 hours you were given to provide the additional information.

To assure you receive notice of our decision, we will contact you by telephone or facsimile (fax) or by another method meant to provide the decision to you quickly.

In determining whether a claim involves urgent care, the plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. **However, if a *physician* with knowledge of your medical condition determines that an *appeal* involves urgent care, or an emergency, the *appeal* must be treated as an urgent care appeal.**

Continuing Coverage: The plan cannot terminate your benefits until all of the appeals have been exhausted. However, if the plan's decision is ultimately upheld, you may be responsible for paying any outstanding claims or reimbursing the plan for claims' 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.

Defined terms: Any terms appearing in italics are defined.

Emergency medical services: If the plan denies a claim for an emergency medical service, your *appeal* will be handled as an urgent *appeal*. The plan will advise you at the time it denies the claim that you can file an expedited internal appeal. If you have filed for an expedited internal *appeal*, you may also file for an expedited external review (see "Simultaneous urgent claim, expedited internal review and external review").

Rescission of coverage: If the plan rescinds your coverage, you may file an *appeal* according to the following procedures. The plan cannot terminate your benefits until all of the appeals have been exhausted. Since a rescission means that no coverage ever existed, if the plan's decision to rescind is upheld, your premium will be returned minus any benefits paid. You will be responsible for payment of all claims for your health care services.

Your Rights to a full and fair review. The plan must allow you to review the *appeal* file and to present evidence and testimony as part of the internal *appeals* and *appeals* process.

1. The plan must provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the appeal; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal *adverse benefit determination* is required to give you a reasonable opportunity to respond prior to that date; and
2. Before the plan can issue a final internal *adverse benefit determination* based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal *adverse benefit determination* is required to be provided to give you a reasonable opportunity to respond prior to that date.
3. The adverse determination must be written in a manner understood by you, or if applicable, your *authorized representative* and must include all of the following:
    a. The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);
    b. Information sufficient to identify the claim involved, including the date of service, the healthcare provider; and
    c. A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

4. As a general matter, the plan may uphold a denial upon *appeal* on the basis that it does not have sufficient information; such a decision; however, will allow you to advance to the next stage of the appeals process.

Other Resources to help you

Department of Insurance: For questions about your rights or for assistance you may also contact the Consumer Services Division at the Arkansas Insurance Department (800) 852-5494. You have the right to file a *complaint* with the Arkansas Insurance Department (AID). You may call AID to request a *complaint* form at (800) 852-5494 or (501) 271-2640, complete the *complaint* form online by visiting https://www.insurance.arkansas.gov/pages/consumer-services/,or write the Department at 1 Commerce Way, Suite 102, Little Rock, AR 72202.

Language services are available from the health benefit plan.

Your rights to appeal and the instructions for filing an appeal are described in the provisions following this Overview.

Simultaneous urgent *appeal* and expedited internal review:

In the case of an *appeal* involving urgent care, you or your *authorized representative* may also request an expedited internal review. A request for expedited internal review may be submitted orally or in writing by the appellant; and all necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the appellant by telephone, facsimile, or other expeditious method.

The *physician*, if the *physician* certifies, in writing, that you have a medical condition where the time frame for completion of an expedited review of an internal *appeal* involving an *adverse benefit determination* would seriously jeopardize the life or health of you or jeopardize your ability to regain maximum function, you may file a request for an expedited external review to be conducted simultaneously with the expedited internal *appeal*.

Simultaneous urgent appeal, expedited internal review and external review:

You, or your *authorized representative,* may request an expedited external review if both the following apply:

1. You have filed a request for an expedited internal review; and
2. After a *final adverse benefit determination*, if either of the following applies:
   a. Your treating provider certifies that the *adverse benefit determination* involves a medical condition that could seriously jeopardize the life or health of you, or would jeopardize your ability to regain maximum function, if treated after the time frame 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.

Concurrent Care Decisions

Reduction or termination of ongoing plan of treatment: If we have approved an ongoing plan or course of treatment that will continue over a period of time or a certain number of treatments and we notify you that we have decided to reduce or terminate the treatment, we

will give you notice of that decision allowing sufficient time to *appeal* the determination and to receive a decision from us before any interruption of care occurs.

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

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

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

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

If the request is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request must be treated as a request involving urgent care and decided in accordance with the urgent care request timeframes, e.g., as soon as possible, taking into account the medical emergencies, but not later than 72 hours after receipt.

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

Members should submit all documentation to us at:

Ambetter from Arkansas Health & Wellness
Attn: Claims Disputes
PO Box 5000
Farmington, MO 63640-5000

EXTERNAL REVIEW

Right to External Review

Under certain circumstances, you have a right to request an external review of our adverse benefit decision by an independent review organization or by the Insurance Commissioner, or both.

If you have filed internal claims and *appeals* according with the procedures of this plan, and the plan has denied or refused to change its decision, or if the plan has failed, because of its actions or its failure to act, to provide you with a final determination of your *appeal* within the

time permitted, or if the plan waives, in writing, the requirement to exhaust the internal claims and *appeals* procedures, you may make a request for an external review of an *adverse benefit determination*.

All requests for an external review must be made within four months of the date of the notice of the plan's *final adverse benefit determination*. Standard requests for an external review must be provided in writing; requests for expedited external reviews, including experimental/investigational, may be submitted orally or electronically. When an oral or electronic request for review is made, written confirmation of the request must be submitted to the plan no later than five calendar days after the initial request was made.

When filing a request for external review, you will be required to authorize the release of any of your medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

You must file the request for an external review using the required forms provided by the Arkansas Insurance Department. For more information, write to:

Arkansas Insurance Department

External Review Division

1 Commerce Way, Suite 102, Little Rock, AR 72202

insurance.Consumers@arkansas.gov

Information about external reviews is also available on the Department's website: https://www.insurance.arkansas.gov/consumer-services/.

Non-urgent request for an external review

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

1. The name and contact information for the assigned Independent Review Organization (IRO) or the Insurance Commissioner, as applicable, for the purpose of submitting additional information; and
2. Except for when an expedited request is made, a statement that you may, with ten business days after the date of receipt of the notice, submit, in writing, additional information for either the Independent Review Organization (IRO) or the Insurance Commissioner to consider when conducting the external review.

If the plan denies your request for an external review because you have failed to exhaust the internal appeals procedure, we will provide you with a written explanation of reasons you were not eligible for an external review because you did not comply with the required procedures.

If the Arkansas Insurance Department upholds the plan's decision: If you file a request for an external review with the Arkansas Insurance Department, and if the Insurance Commissioner upholds the plan's decision to deny the external review because you did not

follow the plan's internal claims and *appeals* procedures, you must resubmit your *appeal* according to the plan's internal claims and appeals procedures within 10 calendar days of the date of your receipt of the Insurance Commissioner's decision. The clock will begin running on all of the required time periods described in the internal claims and appeals procedures when you receive this notice from the Insurance Commissioner.

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

Expedited external review : You may have an expedited external review if your treating provider certifies that the *adverse benefit determination* involves a medical condition that could seriously jeopardize the life or health of you (appellant), or would jeopardize your ability to regain maximum function if treated after the time frame for a standard external review; or the *final adverse benefit determination* concerns an admission, availability of care, continued stay, or health care service for which you received *emergency services*, but have not yet been discharged from a facility.

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

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

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

If the request for an expedited external review is complete and eligible, the plan will immediately provide or transmit all necessary documents and information considered in making the *adverse benefit determination* in question to the assigned independent review organization (IRO) by telephone, facsimile or other available expeditious method.

If the request is not complete, we will notify you immediately, including what is needed to make the request complete.

Independent Review Organization (IRO): An external review is conducted by an independent review organization (IRO) selected on a random basis as determined in accordance with Arkansas law. The IRO will provide you with a written notice of its decision to either uphold or reverse the plan's *adverse benefit determination* within 45 calendar days of receipt of a standard external review (not urgent).

If an expedited external review (urgent) was requested, the IRO will provide a determination as soon as possible or within 72 hours of receipt of the expedited request. The IRO's decision is binding on the company. If the IRO reverses the health benefit plan's decision, the plan will immediately provide coverage for the health care service or services in question.

If the Insurance Commissioner or IRO requires additional information from you or your healthcare provider, the plan will tell you what is needed to make the request complete.

If the plan reverses its decision: If the plan decides to reverse its adverse determination before or during the external review, the plan will notify you, the IRO, and the Insurance Commissioner within one business day of the decision.

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

Emergency medical services: If plan denies coverage for an emergency medical service, the plan will also advise at the time of denial that you request an expedited internal and external review of the plan's decision.

If the IRO and Insurance Commissioner **uphold the plan's decision**, you may have a right to file a lawsuit in any court having jurisdiction.

Grievance

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

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

Filing a Grievance

You or your *authorized representative* may file a *grievance* by calling Member Services or in writing by mailing or faxing your *grievance* to:
Ambetter from Arkansas Health & Wellness
Attn: Appeals and Grievance Department
P.O. Box 10341
Van Nuys, CA 91410
Fax: 1--833-886-7956
Phone: 1-877-617-0390 (TTY 1-877-617-0392)

If filing a written *grievance*, please include:

1. Your first and last name
2. Your member ID number

3. Your address and telephone number
4. Details surrounding your concern
5. Any supporting documentation

Grievance Process and Resolution Timeframes

We will acknowledge your *grievance* by sending you a letter within five business days of receipt of your *grievance*.

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

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

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

Appeal and Grievance Filing and Key Communication Timelines

	Timely Filing	Acknowledgment	Resolution
Standard Grievance	N/A	5 Business Days	30 Calendar Days
Expedited Grievance	N/A	N/A	3 Business Days
Standard Pre-Service Appeal	180 Calendar Days	5 Business Days	30 Calendar Days
Expedited Pre-Service Appeal	180 Calendar Days	N/A	72 Hours
Standard Post-Service Appeal	180 Calendar Days	5 Business Days	60 Calendar Days
External Review	4 months	N/A	45 Calendar Days**
Expedited External Review	120 Calendar Days	N/A	72 Hours**

**Not including the time it takes for the Arkansas Insurance Department to process, us to determine eligibility, and IRO to receive external review.

GENERAL PROVISIONS

Entire Contract

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

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

All riders or endorsements added to the *policy* after the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the *policy* shall require signed acceptance by the *member*. After date of *policy* issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the *policy* term must be agreed to in writing signed by the member, except if the increased benefits or coverage is required by law.

Reinstatement

If any renewal premium is not paid within the time granted the *member* for payment, a subsequent acceptance of premium by the insurer or by any agent *authorized* by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the *policy*; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the *policy* will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the *member* in writing of its disapproval of such application. The reinstated *policy* shall cover only *loss* resulting from such accidental *injury* as may be sustained after the date of reinstatement and *loss* due to such sickness as may begin more than 10 calendar days after such date. In all other respects, the *member* and insurer shall have the same rights thereunder as they had under the *policy* immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 calendar days prior to the date of reinstatement.

Non-Waiver

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

Rescissions

No misrepresentation of fact made regarding a *member* during the application process that relates to insurability will be used to void/rescind the insurance 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 *policy* or in filing a claim for *policy* benefits, we have the right to demand that *member* pay back to us all benefits that we paid during the time *member* was insured under the *policy*. If it is determined that the *policy* should not have been issued or that benefits were paid due to fraud, misrepresentation or false information, premiums paid on behalf of the *member* will be returned, minus the total amount of all benefits paid on behalf of the *member*.

Conformity with Applicable Laws

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

Personal Health Information (PHI)

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

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

Conditions Prior to Legal Action

On occasion, we may have a disagreement related to coverage, benefits, premiums, or other provisions under this *policy*. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process.

Time Limit on Certain Defenses

After three years from the date of issue of this *policy*, no misstatements, except fraudulent misstatements, made by the applicant in the application for such *policy* shall be used to void the *policy* or to deny a claim for *loss* incurred or disability as defined in the *policy* commencing after the expiration of such 3-year period.

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities, or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that *policy* and contract owners will be protected, within certain limits, in the unlikely event that a *member* insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other *member* insurance companies for the money to pay the claims of *policy* and contract owners who live in this state and, in some cases, to keep coverage in force. Please note that the valuable extra protection provided by the *member* insurers through the Guaranty Association is limited. This protection is not a substitute for a consumer's careful consideration in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") provides coverage of claims under some types of policies or contracts if the insurer or health maintenance organization becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in the State of Arkansas. Other conditions may also preclude coverage.

The Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer or health maintenance organization and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy or health maintenance organization coverage.

You should not rely on availability of coverage under the Guaranty Association when selecting an insurer or health maintenance organization.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, Arkansas 72201

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

The state law that provides for this safety net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"), which is codified at Ark. Code Ann. §§ 23-96-101, et seq. Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not

cover all provisions of the Act, nor does it in anyway change any person's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

Coverage

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or *policy*, or if they are insured under a group insurance contract issued by a *member* insurer. The beneficiaries, payees or assignees of *policy* or contract owners are protected as well, even if they live in another state.

Exclusions from Coverage

However, persons owning such policies are NOT protected by the Guaranty Association if:

1. They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
2. The insurer was not *authorized* to do business in this state; or
3. Their *policy* or contract was issued by a hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the *policy* or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

1. Any *policy* or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
2. Any *policy* of reinsurance (unless an assumption certificate was issued);
3. Interest rate yields that exceed an average rate;
4. Dividends, voting rights, and experience rating credits;
5. Credits given in connection with the administration of a *policy* by a group contract holder;
6. Employer plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
7. Unallocated annuity contracts (which give rights to group contract holders, not individuals);
8. Unallocated annuity contracts issued to or in connection with benefit plans protected under the Federal Pension Benefit Corporation ("FPBC"), regardless of whether the FPBC is yet liable;
9. Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
10. Portions of a *policy* or contract to the extent assessments required by law for the Guaranty Association are preempted by state or federal law;

11. Obligations that do not arise under the *policy* or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, claims for *policy* misrepresentations, and extra-contractual or penalty claims; or
12. Contractual agreements establishing the *member* insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustee(s).

Limits on Amount of Coverage

The Act also limits the amount the Guaranty Association is obligated to cover. The Guaranty Association cannot pay more than what the insurance company would owe under a *policy* or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 in life insurance death benefits without regard to the number of policies and contracts there were with the same company, even if they provided different types of coverage. The Guaranty Association will pay a maximum of $500,000 in health benefits, provided that coverage for disability insurance benefits and long-term care insurance benefits shall not exceed $300,000. The Guaranty Association will pay $300,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits. These are limitations under which the Guaranty Association is obligated to operate prior to considering either its subrogation and assignment rights or the extent to which those benefits could be provided from the assets of the impaired or insolvent insurer.