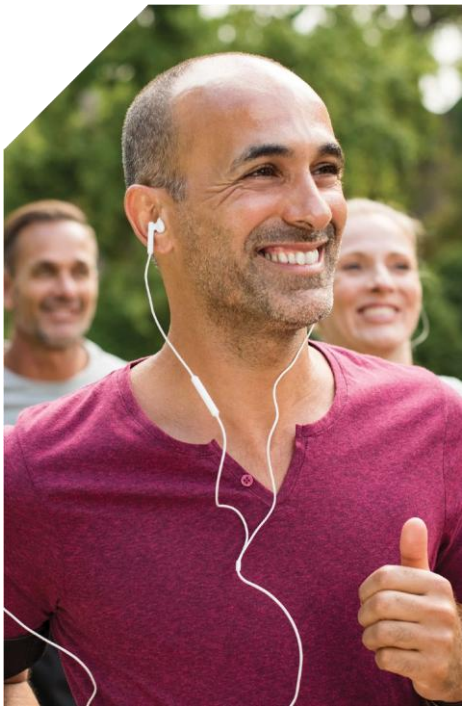
ambetter. FROM arizona complete health



2027 EVIDENCE OF COVERAGE

AmbetterHealth.com/en/AZ

91450AZ008-2027

MAJOR MEDICAL EXPENSE INSURANCE POLICY

AMBETTER FROM ARIZONA COMPLETE HEALTH

Home Office: 1850 W. Rio Salado Parkway, Suite 211, Tempe, AZ 85281

Issued by

AMBETTER FROM ARIZONA COMPLETE HEALTH

Welcome to Ambetter from Arizona Complete Health. This *policy* explains what your benefits are, how you can access these benefits, and the limitations and exclusions that apply to *covered services*. 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 Arizona Complete Health. For your convenience, we have included a Definitions section, which will explain the meaning of special words and phrases used throughout this *policy*. Be sure to check these definitions as they may differ from other health plans.

AGREEMENT AND CONSIDERATION

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

GUARANTEED RENEWABLE

Annually, we must file this product, the *cost share* and the rates associated with it for approval. Guaranteed renewable means that your *policy* will be renewed into the subsequent year's approved product on the anniversary date unless terminated earlier in accordance with *policy* terms. You may keep this *policy* (or a new *policy* you are enrolled into for the following year) in force by timely payment of the required premiums. In most cases, you will be enrolled into a new *policy* at the same metal level with a similar type and level of benefits. We may decide not to renew the *policy* as of the renewal date if:

1. We decide not to renew all policies issued on this form to residents of the state,
2. We withdraw from the *service area*, or
3. There is fraud or an intentional material misrepresentation made by or with the knowledge of a *member* in filing a claim for *policy* benefits.

In addition to the above, this guarantee of continuity of coverage shall not prevent us from cancelling or non-renewing this *policy* in the following events:

1. Non-payment of premium,
2. A *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the *policy*, or
3. A change in federal or state law no longer permits the continued offering of such coverage, such as CMS guidance related to individuals who are Medicare eligible.

Annually, we will change the rate table used for this *policy* form. Each premium will be based on the rate table in effect on that premium's due date. The *policy* plan, and age of *members*, type and level of benefits, and place of residence on the premium due date are some of the factors used in

determining your premium rates. We have the right to change premiums, however, all premium rates charged will be guaranteed for a *calendar year*.

At least 31 calendar days' notice of any plan to take an action or make a change permitted by this clause will be delivered to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under this *policy* or a change in a *member's* health. While this *policy* is in force, we will not restrict coverage already in force. Changes to this *policy* must be approved by the Arizona Department of Insurance and Financial Institution prior to implementation.

This policy contains *authorization* requirements. You may be required to obtain a referral from a *primary care physician (PCP)* in order to receive care from a specialist provider. Benefits may be reduced or not covered if the requirements are not met. Please refer to your *Schedule of Benefits* and the Utilization Management section.

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

RIGHT TO RETURN

This *policy* should be read carefully. If you have questions, call Member Services at 1-888-926-5057 (TTY: 711). If you are not satisfied with this *policy*, you may return it, in person or by mail, along with your *member* identification card to Ambetter from Arizona Complete Health, 1850 W. Rio Salado Parkway, Suite 211, Tempe, Arizona 85281, within ten calendar days from the date it was received so long as *covered services* under this *policy* have not been utilized during the ten-day period. Immediately upon such delivery or mailing, this *policy* shall be deemed void as of its original *effective date*. Any premium paid will be refunded back to the original method of payment and/or payee within ten calendar days of Arizona Complete Health's receipt of the returned *policy*.

Arizona Complete Health
By:

James Stover
Plan President & CEO, Arizona Complete Health

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INTRODUCTION

PLEASE READ THIS IMPORTANT NOTICE ABOUT YOUR POLICY

AMBETTER FROM ARIZONA COMPLETE HEALTH SERVICE AREA AND OBTAINING SERVICES FROM THE NETWORK PHYSICIANS HOSPITAL PROVIDERS

You are enrolled in an Ambetter from Arizona Complete Health *policy*. Benefits under this *policy* are only available when you use an Ambetter from Arizona Complete Health *network provider* (except as stated below) and live in the Ambetter from Arizona Complete Health *service area*.

Please refer to this *policy* whenever you require *medical services*. It describes how to access medical care, the health care services we cover, and the portion of your health care costs you will be required to pay.

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

If you have any questions about Ambetter from Arizona Complete Health, choosing your *primary care physician* (*PCP*), how to access *specialist* care, or your benefits, please contact Member Services at 1-888-926-5057 (TTY: 711).

How to Contact Us

Ambetter from Arizona Complete Health
1850 W. Rio Salado Parkway, Suite 211
Tempe, AZ 85281

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

Member Services:.....	1-888-926-5057
TTY:.....	711
Fax:.....	1-866-687-0518
Emergency:	911
Suicide and Crisis Lifeline:	988 (call or text)
24/7 Nurse Advice Line:....	1-888-926-5057 (TTY: 711)

Language Assistance

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

Our interpreters 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 reading documents can call Member Services for an oral interpretation or to have documents translated into braille or large font.

To arrange for interpreter services, please call Member Services.

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 is HSA compliant. 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 and underwritten by Ambetter from Arizona Complete Health. Neither entity is an HSA trustee, HSA custodian or a designated administrator for HSAs. Ambetter from Arizona Complete Health, its designee and its affiliates, including Ambetter from Arizona Complete Health, 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.

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 your providers.
3. Providing information to help you become an informed health care consumer.
4. Providing access to *covered services* and our *network providers*.
5. Providing coverage regardless of age, ethnicity, race, religion, gender identity, sexual orientation, national origin, physical or mental disability, and/or expected health or genetic status.

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

You have the right to:

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

7. Candidly discuss with your *physician* and medical practitioners appropriate and *medically necessary* care for your condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *PCP* about what might be wrong (to the level known), treatment and any known likely results. Your *PCP* can tell you about treatments that may or may not be covered by this *policy*, regardless of the cost. You have a right to know about any costs you will need to pay. This should be told to you in words you can understand. When it is not appropriate to give you information for medical reasons, the information can be given to a legally *authorized representative*. Your *physician* will ask for your approval for treatment unless there is an emergency, and your life and health are in serious danger.
8. Voice complaints or *grievances* about our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
9. See your medical records.
10. Be kept informed of covered and non-covered services, program changes, how to access services, *PCP* assignment, providers, advance directive information, *referrals* and authorizations, benefit denials, *member* rights and responsibilities, and our other rules and guidelines. We will notify you at least 30 calendar days before the *effective date* of the modifications. Such notices shall include a statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
11. A current list of *network providers*.
12. Select another health plan or switch health plans, within the guidelines of law, without any threats or harassment.
13. Adequate access to qualified *physicians* and medical practitioners and treatment or services regardless of age, ethnicity, race, religion, gender identity, sexual orientation, national origin, physical or mental disability, and/or expected health or genetic status.
14. Access *medically necessary* urgent and *emergency services* 24 hours a day, seven days a week.
15. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.
16. Refuse treatment to the extent the law allows without jeopardizing future treatments and be informed by your provider(s) of the medical consequences. You are responsible for your actions if treatment is refused or if the *PCP's* instructions are not followed. You should discuss all concerns about treatment with your *PCP*. Your *PCP* can discuss different treatment plans with you, if there is more than one option that may help you. You will make the final decision.
17. Select your *PCP* within the *network*. You also have the right to change your *PCP* or request information on *network providers* close to your home or work.
18. Know the name and job title of people giving you care. You also have the right to know which *physician* is your *PCP*.
19. An interpreter, available by phone, if you do not speak or understand English.

20. A second opinion by a *network provider* of your choice, if you want more information about your treatment or would like to explore additional treatment options.
21. Make an advance directive for health care decisions. This includes planning treatment before you need it. Advance directives are forms you can complete to protect your rights for medical care. It can help your *PCP* and other providers understand your wishes about your health. Advance directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself. *Members* also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive. Examples of advance directives include:
    1. Living Will
    2. Healthcare Power of Attorney
    3. “Do Not Resuscitate” orders

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 questions of your *physician* until you understand the care you are receiving.
4. Review and understand the information you receive about us. You need to know the proper use of *covered services*.
5. Show your *member* identification card and keep scheduled appointments with your *physician* and call the *physician’s* office during office hours whenever possible if you have a delay or cancellation.
6. Know the name of your *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. Understand your health problems and participate, along with your healthcare professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Follow the treatment plans and instructions for care that you have agreed on with your healthcare professionals and *physicians*.
10. 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 provider to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.
11. Follow all health benefit plan guidelines, provisions, policies and procedures.

12. Use any emergency room only when you think you have a medical emergency. For all other care, you should call your *PCP* or access an urgent care facility.
13. 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.
14. Pay your monthly premium, *deductible amount*, *copayment amounts*, and *coinsurance amounts* on time.
15. Receive all of your health care services and supplies from *network providers*, except as specifically stated in this *policy*.
16. Inform the entity in which you enrolled if you have any changes that would affect your *policy* within 60 calendar days of the event. Enrollment related changes include birth of a child, adoption, marriage, divorce, change of address, adding/removing a *dependent member*, *spouse*/domestic partner becomes eligible under a different insurer, or incarceration where *member cost share* would need to transfer from one *policy* to another *policy*.

IMPORTANT INFORMATION

Your Provider Directory

A listing of *network providers* is available online at AmbetterHealth.com/en/AZ. We have plan *physicians*, *hospitals*, and other medical practitioners who have agreed to provide you with health care services. You may find any of our *network providers* by accessing the "Find a Doctor" page on our website and selecting the Ambetter *network*. There you will have the ability to narrow your search by provider specialty, zip code, gender, languages spoken and whether or not they are currently accepting new patients. Your search will produce a list of providers based on your search criteria and will give you other information such as 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 *network PCP* for each *member*. We can help you pick a *PCP*. We can make your choice of *PCP* effective on the next business day, if the selected *physician's* caseload permits. We will notify you if your *PCP* leaves our *network*. You will be provided continued access, and your coverage will continue under the terms of this *policy* for at least 90 calendar days from that notice.

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

You may also contact us at 1-888-926-5057 or through the web form located at AmbetterHealth.com/en/AZ to request information about whether a *physician*, *hospital*, or other medical practitioner is a *network provider*. We will respond to any such requests within one business day.

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

Your Member Identification Card

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

Our 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/AZ. 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 with your Ambetter from Arizona Complete Health plan.
7. Our *formulary*.
8. Selecting a *PCP*.
9. *Deductible* and *copayment amounts*.

Quality Improvement

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

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

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

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

Protection from Balance Billing

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

DEFINITIONS

This section tells you meanings of some of the more important words you will see used in this *policy*. Please read it carefully. It will help you understand this *policy*. In this *policy*, italicized words are defined. Words that are not italicized will be given their ordinary meaning.

Wherever used in this *policy*:

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

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

Advance premium tax credit means payment of the tax credits specified in section 36B of the Internal Revenue Code (as added by section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual enrolled in a *qualified health plan* through a Marketplace in accordance with sections 1402 and 1412 of the Affordable Care Act. If we do not receive *advance premium tax credits* with respect to your coverage for whatever reason, your coverage may be terminated.

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 rescission of coverage determination as described in the General Provisions section of this *policy*.
7. A prospective review or retrospective review determination that denies, reduces or fails to provide or make payment, in whole or in part, for a *covered service*.

Refer to the Grievance, Health Care Appeals and External Review Procedures section of this *policy* for information on your right to appeal an *adverse benefit determination*.

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

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

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

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

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

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

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

Authorization or ***authorized*** means a determination by us, which has been reviewed and, based on the information provided, satisfies the requirements to approve based on the *medical necessity* or the appropriateness of care for a *member* by the *member's PCP* or provider and that payment under the plan will be made for that health care service.

Authorized representative means an individual who represents a *member* in a *health care 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 appeal process or external review process of an *adverse benefit determination*,
2. A person *authorized* by law to provide substituted consent for a covered individual, or
3. A family member or a treating health care professional, but only when the *member* is unable to provide consent.

Autism spectrum disorder means a neurological and developmental disorder that begins early in childhood and lasts throughout a person's life. It is a condition related to brain

development that impacts how a person perceives and socializes with others, causing problems in social interaction and communication. It may include intellectual impairment but not always. The disorder may include problems with the ability to recognize or share interests or emotional experiences, problems expressing or understanding verbal or non-verbal communication, and/or developing or maintaining relationships. Repetitive patterns of behavior or an inability to tolerate change are often seen.

Balance billing means a *non-network provider* billing you for the difference between the provider's charge for a service and the *eligible expense* for *covered services*. *Network providers* may not balance bill you for *covered services* beyond your applicable *cost sharing* amounts. If you are ever *balanced 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 *balanced 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 *balanced billed* by the *non-network provider*, or
3. Air ambulance services provided to a *member* by a *non-network provider*.

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

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

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

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

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

Center of Excellence means a *hospital* that specializes in a specific type or types of *medically necessary* transplants or other *medical services* and has agreed with us or an entity

designated by us to meet quality of care criteria on a cost-efficient basis. The fact that a *hospital* is a *network provider* does not mean it is a *Center of Excellence*.

Coinsurance or ***coinsurance amount*** means the percentage of *covered services* that you are required to pay when you receive a covered service. *Coinsurance amounts* are listed in the *Schedule of Benefits*. For example, *coinsurance* may be shown as 20 percent. This means that 20 percent of the *covered service* is paid by the *member* and 80 percent is paid by us. Not all *covered services* have *coinsurance amounts*.

Complications of pregnancy means an emergency cesarean section or a non-elective cesarean section or a condition whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy, or are caused by pregnancy and not, from a medical viewpoint, associated with a normal pregnancy. This includes ectopic pregnancy, spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity.

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

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

1. Undergoing treatment for a *serious and complex condition* from that provider or facility,
2. Undergoing a course of institutional or *inpatient care* from that provider or facility,
3. Scheduled to undergo non-elective surgery from that provider, including postoperative care,
4. Pregnant and undergoing a course of treatment for the pregnancy, or
5. Determined to be terminally ill and receiving treatment for such *illness*.

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

Cosmetic or ***cosmetic surgery*** means surgical procedures, including plastic surgery or other treatment that we determine to be directed toward preserving, altering or enhancing appearance, whether or not for emotional or psychological reasons.

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

Cost sharing reductions mean the reduction of the amount you have to pay in *deductibles, copayments* and *coinsurance*. To qualify for *cost sharing reductions*, an eligible *member* must enroll in a silver level plan in 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(s) means *medically necessary* services, supplies or benefits that are payable or eligible for reimbursement under this *policy*, including any amendments hereto

subject to any benefit limitations, or maximums under this *policy* and/or performed by providers within the scope of their practice. The fact that a *network provider* may prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it a *covered service*.

Custodial care means provision of room and board, nursing care (excluding skilled nursing care), and personal care designated to assist an individual who in the opinion of our Medical Director has reached the maximum level of recovery. *Custodial care* also includes rest cures, *respite care*, and home care that is or can be performed by family members or non-medical personnel.

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

Dependent member means the primary *subscriber's* lawful *spouse*, domestic partner or an *eligible child*. Each *dependent member* must either be named in the enrollment application, or we must agree in writing to add them as a *dependent member*. The term *dependent member* does not include a person who is a *member's* natural child for whom legal rights have been given up through adoption, or a grandchild of the *member* for whom the *member* does not have court ordered permanent guardianship or custody.

Durable medical equipment or ***DME*** 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 applicable date coverage under this *policy* became effective.

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

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

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

Eligible expense or ***allowable amount*** means a *covered service* as determined below.

1. For *network providers*: When a *covered service* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.

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

Emergency condition means a medical condition or a *behavioral health* condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such 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 any of the following:

1. Placing the health, including mental 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 a bodily function of the *member*,
3. Serious dysfunction of any bodily organ or part of the *member*,
4. Harm to the *member* or others.

Emergency services mean *covered services* needed to evaluate and *stabilize* an *emergency condition*. This includes a medical screening examination in a *hospital* emergency department (including labor and delivery departments) or independent freestanding emergency department to evaluate the *emergency condition*, as well as services needed to *stabilize* the *emergency condition*. Services to *stabilize* an *emergency condition* can be provided in any department of a *hospital*. Follow-up care is not considered part of *emergency services*.

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

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

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:

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.

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

Formulary means a guide to available brand and *generic drugs* that are approved by the United States Food and Drug Administration (FDA) and covered through your *prescription drug* benefit. *Generic drugs* have the same active ingredients as their brand name counterparts and should be considered the preferred, 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 to help identify brand drugs that are clinically appropriate, safe and cost-effective treatment options, if a *generic* medication on the *formulary* is not suitable for your condition.

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

If no credible scientific evidence is available, then standards based on *physician* specialty society recommendations or professional standards of care may be considered. We reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered service* under the *policy*. The decision to apply *physician* specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by us.

Generic drug or ***generic*** means a drug product, containing identical active ingredients to the brand name product, which the FDA has determined to be therapeutically equivalent to the original brand name product and classified as such by national pharmaceutical database companies.

Grievance means any complaint or dispute expressing dissatisfaction with any aspect of the operations, activities, or behavior, other than an *adverse benefit determination*, of a Marketplace health plan, or its providers, regardless of whether remedial action is requested.

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

Health care appeal means any request by you or your representative to reverse, rescind, or otherwise modify an *adverse benefit determination*.

Health professional means a health care provider who is appropriately licensed, certified or otherwise qualified to deliver health services pursuant to state law and providing services within the scope of their license, and who has contracted with us to render *medical services* to our *members*.

Home health care means medical care provided by a *network provider* from an approved *home health care agency* which is provided on an interim basis, or in lieu of hospitalization.

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

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

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*. We work with certified *hospice* programs licensed by the state to minimize patient discomfort and address the special physical, psychological, and social needs of terminally ill *members* and their *immediate family*.

Hospital means an institution that:

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

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation* facility, *extended care facility*,

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

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

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

Injury means an accidental bodily *injury* that is caused directly and independently of all other causes by an accident.

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

Intermittent means nursing services (including services separated in time, such as two hours in the morning and two hours in the evening) that do not exceed a total of four hours in any 24-hour period.

Loss means an event for which benefits are payable to a *member* under this *policy*. Expenses incurred prior to this *policy's effective date* are not covered, however, expenses incurred beginning on the *effective date* of insurance under this *policy* are covered.

Maintenance means services and supplies that are provided solely to maintain a condition at the level to which it has been restored or *stabilized* and from which level no significant practical improvement can be expected as determined by us.

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

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

Medical services mean those professional services of a *physician* and allied *health professionals*, including medical, surgical, diagnostic, and therapeutic services which are described in the section titled, Major Medical Expense Benefits, and which are performed, prescribed or directed by a *network physician* within the scope of their license.

Medically necessary or ***medical necessity*** means our decision as to whether health care services that a health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an *illness*, *injury*, disease or its symptoms:

1. In accordance with *generally accepted standards of medical practice*;

2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's *illness, injury* or disease; and
3. Not primarily for the convenience of the patient, *physician*, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's *illness, injury* or disease.

For these purposes, "*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, Physician Specialty Society recommendations, the views of *physicians* practicing in relevant clinical areas and any other relevant factors.

The fact that a provider may prescribe, order, recommend or approve a treatment, service, supply or medicine does not in itself make the treatment, service, supply or medicine *medically necessary* as defined in this *policy*. The terms *medically necessary*, medically indicated, and *medical necessity* may be used interchangeably throughout this document.

Member means any person enrolled under this *policy*, including you, your *spouse*/domestic partner or *eligible child*, for whom premium payment has been received and accepted by our Accounts Receivable Department. **Note:** *Member* also includes a newborn for the first 31 calendar days in accordance with the definition of *newborn period*.

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

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

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

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

Newborn period means the first 31 calendar days following birth to a covered member or legal adoption by a covered member. For the purposes of *cost sharing* application, newborns are considered to be enrolled *members* for the first 31 calendar days.

Non-network provider means any provider, *provider facility*, or other provider who is NOT a *network provider* because they have not entered into a contract directly or indirectly with Ambetter from Arizona Complete Health. Services received from a *non-network provider* are not covered, except for:

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

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

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

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 their licensed authority in treating a bodily *injury* or *illness* and is required to be covered by state law.

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

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

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 an *inpatient* or *outpatient* stay with respect to the visit in which other *emergency services* are furnished.

Primary care physician (PCP) means a *physician* who supervises, directs, and gives initial care and basic *medical services* to you and is in charge of your ongoing care. *PCP's* include internists, family practitioners, general practitioners, advanced practice registered nurses (APRN), *Physician* Assistants (PA), Obstetricians/Gynecologists (OB/GYN) and pediatricians.

Prior authorization means a determination by us that a health care service, treatment plan, *prescription drug* or *durable medical equipment* is *medically necessary*. We require *prior authorization*, including preadmission review, pretreatment review, prospective review or *utilization review* procedures conducted by us for certain services before you receive them, except in an emergency. *Prior authorization* does not include any different or additional procedures, services, or treatments beyond those specifically reviewed and approved by us. A *prior authorization* request, once granted or deemed granted, is binding and may be relied on by the *member* and provider and may not be rescinded or modified by us after the provider renders the *authorized* health care services in good faith and pursuant to the *authorization* unless there is evidence of fraud or misrepresentation by the provider.

Private duty nursing means services that are provided in a *hospital* room from a Registered Nurse (RN) or a Licensed Practical Nurse (LPN), in accordance with a *physician's* care plan. *Private duty nursing* services are provided by a licensed nurse that is prescribed on an *intermittent* basis while the patient is *inpatient* in a *medically necessary* acute hospitalization.

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

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

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

Qualified health plan or ***QHP*** means an insurance plan that's certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like *deductibles, copayments*, and *maximum out-of-pocket amounts*), and meets other requirements under the Affordable Care Act. All *qualified health plans* meet the Affordable Care Act requirement for having health coverage, known as "*minimum essential coverage*".

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

Qualified travel expenditures mean transportation, room and board costs incurred while obtaining *authorized covered services* outside the *service area* in cases where it has been determined by us that the *authorized covered services* are not available in the *service area*. Refer to the Transplant Services – Organ & Tissue benefit under the Major Medical Expense Benefits section in this *policy* for a description of *covered services* and limitations that apply.

Referral means the request made through the *PCP* for *authorization* of specialty services or equipment on behalf of a *member*. In order for services to be covered, *referrals* must be approved by us, prior to the *member* receiving specialty services.

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*, long-term acute care hospitalization, or intensive day *rehabilitation*, and it includes *rehabilitation therapy* and cardiac *rehabilitation therapy*. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been medically *stabilized* and begins to receive *rehabilitation therapy* or treatment.

Rehabilitation 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.

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

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

Routine care means *routine care* that includes, but is not limited to, conditions such as colds, flu, sore throats, superficial *injuries*, minor infections, follow-up care and preventive care. Treatment for these conditions should be sought from a *PCP* and are not considered *emergency services*.

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

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

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 Arizona to sell and market our health plans. This is where the majority of *network providers* are located where you will receive all of your health care services and supplies. You can receive precise *service area* boundaries from our website or Member Services.

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

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

Special enrollment period means individuals who experience certain qualifying events can enroll in or change enrollment outside of the initial and annual open enrollment periods. The *effective date* of coverage depends on the qualifying events.

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

Spouse means the person to whom you are lawfully married.

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

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

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

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

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

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

Telehealth or ***telehealth services*** means the mode of delivering health care services and public health via information and the interactive use of audio, video, or other electronic media to facilitate the diagnosis, consultation, treatment, education, *care management*, and self-management of a patient's health care while the patient is at the originating site and the provider for *telehealth* is at a distant site. *Telehealth services* include synchronous interactions and asynchronous store and forward transfers but do not include the sole use of a fax machine, instant messages, voice mail or email.

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

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

Urgent care center means a facility, not including a *hospital* emergency room or a *physician's* office, which 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 management or ***utilization review*** means a prior, concurrent and retrospective process whereby requests for service under this plan are reviewed:

1. For *medical necessity* and appropriateness;
2. For verification that the service is a *covered service*;
3. For verification where benefits have a predetermined limit that *medical services* have not been exceeded, or are being appropriately applied, or applied in a timely manner consistent with the diagnosis and treatment; and
4. For verification that the *member* is eligible for services under this *policy*.

Utilization review performed prior to receipt of services does not guarantee coverage if other plan provisions are not satisfied (for example, *member* is not eligible on date of service).

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

DEPENDENT MEMBER COVERAGE

Dependent Eligibility

Eligible dependents of the *member* may apply for *dependent member* coverage under this *policy*, provided that the family member:

1. Meets the *dependent member* eligibility requirements as defined below; and
2. Satisfies either the discretionary or automatic eligibility requirements as described herein.

Eligible dependents, at the time of enrollment and throughout the term of coverage hereunder, include:

1. A *member's* lawful *spouse*, living within the *service area* serviced by Ambetter from Arizona Complete Health; or
2. A *member's* child under the age of 26. For purposes of this provision, the term child shall include a natural child, stepchild, legally adopted child, a child who has been placed for adoption with the *member*, a child under a *member's* permanent guardianship or permanent custody by court order or a child eligible for coverage pursuant to a Qualified Medical Child Support Order.
3. A *member's eligible child* that is over the age of 26 and:
   a. Was disabled prior to age 26;
   b. Continues to be disabled under federal regulation; and
   c. The *member* or *member's* qualified same-sex domestic partner had custody of the *eligible child* prior to age 26.

If the *eligible child* enrolled under this *policy* is under the age of 21 and has been enrolled by an eligible *member*, the eligible *member* signing for coverage on behalf of the child agrees to be responsible for the administrative and premium requirements of the coverage.

Dependents of the *eligible child* cannot be enrolled and cannot be *members* under this *policy*. No benefits shall be payable on behalf of such dependents.

For purposes of this provision, a child must be younger than 26 years of age as of the date of adoption or placement for adoption. The term *dependent member* does not include a *member's* natural child for whom legal rights have been given up through adoption, or a grandchild of the *member* for whom the *member* does not have court ordered permanent guardianship or custody. Eligibility is not based on any health status related factors.

Enrollment of Newborn, Adopted Child or Child Placed for Adoption

A newborn child, of a covered mother, a legally adopted child of a covered *member*, or child placed for adoption with the *member* is automatically covered under this *policy* for the first 31 calendar days following the date of birth, date of adoption or placement for adoption. To

continue coverage after the first 31 calendar days, the *member* must submit an enrollment application for such a *dependent member* within 60 calendar days of the date of birth, date of adoption or placement for adoption. Failure to enroll a newborn within 60 calendar days following the date of birth will terminate coverage at the end of the initial 31 calendar day period. The continued coverage of the newborn after the initial 31 calendar day period is subject to our receipt of premium payment for such newborn. The newborn will show as an active *member* from the date of birth, adoption, or placement for adoption.

Does not include a person who is a *member's* natural child for whom legal rights have been given up through adoption, or a grandchild of the *member* for whom the *member* does not have court ordered permanent guardianship or custody.

Coverage for Other Dependent Members

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

ELIGIBILITY AND ENROLLMENT

For All Members

A *member's* eligibility for coverage under this *policy* will continue until 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*; or
2. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or
3. The date we decline to renew this *policy*, as stated in the Discontinuance provision; or
4. The date of a *member's* death; or
5. The *subscriber* residing outside the *service area* or moving permanently outside the *service area* of this *policy*; or
6. The date of termination that the Marketplace provides us, upon your request of cancellation to the Marketplace, or if you enrolled directly with us, the date we receive a request from you to terminate this *policy*, or any later date stated in your request.

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

For Dependent Members

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

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

1. Incapable of self-sustaining employment due to mental or physical disability that began before the age limit was reached, and
2. Mainly dependent on the primary *member* for support.

Proof of such incapacity and dependency shall be furnished to Ambetter from Arizona Complete Health by the policyholder within 31 calendar days of the child's attainment of 26 years of age and subsequently as may be required by us but not more frequently than annually after the two-year period following the child's attainment of the age of 26.

Effective Dates of Coverage

Subject to the eligibility and enrollment requirements, coverage under this *policy* shall become effective on the following dates:

1. For the *member* and any enrolled *dependent member* whose enrollment application has been approved by Ambetter from Arizona Complete Health or the Federally Facilitated Marketplace, coverage shall commence on the date stated in Ambetter from Arizona Complete Health or the Federally Facilitated Marketplace's written approval letter.
2. For newly eligible dependents who become eligible after the *member's* original *effective date* of this *policy*, coverage shall be effective as follows:
   a. Newborns of covered *members* are automatically enrolled for the first 31 calendar days from the date of birth. Continued coverage beyond the first 31 calendar days is subject to receipt of a signed enrollment application and payment of additional premium, if required.
   b. Adopted children of a covered parent are automatically enrolled for the first 31 calendar days following date of adoption. Continued coverage beyond the first 31 calendar days is subject to receipt of a signed enrollment application and payment of additional premium, if required.
   c. Other eligible dependents, as defined in this *policy*, will be enrolled from the date specified in a letter approving enrollment and payment of additional premium if required.

Newborn coverage and *cost sharing* does not include a person who is a *member's* natural child for whom legal rights have been given up through adoption, or a grandchild of the *member* for whom the *member* does not have court ordered permanent guardianship or custody.

Please refer to the Newborn Charges provision of this *policy* for *cost sharing* information.

Open Enrollment

Each year, there will be an open enrollment period where you may apply for or change coverage in a qualified health plan (QHP) through the Health Insurance Marketplace for yourself and/or your eligible dependents. The open enrollment period begins on November 1st of the current year and extends through January 15th of the following year. Coverage for *qualified individuals* who enroll on or before December 15th will have an *effective date* of coverage of January 1st of the following year.

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

Special Enrollment Periods

In general, a *qualified individual* has 60 calendar days to report certain life changes, known as "qualifying events," to the Health Insurance Marketplace. If a *qualified individual* loses Medicaid or CHIP coverage that is considered *minimum essential coverage*, they have up to

90 calendar days after the *loss* of *minimum essential coverage* to enroll in a Marketplace plan. *Qualified individuals* may be granted a *special enrollment period* where they may enroll in or change to a different Marketplace plan during the current plan year if they have a qualifying event. Qualifying events include:

1. A *qualified individual* or *dependent member* loses *minimum essential coverage*, non-*calendar year* group or individual health insurance coverage, pregnancy-related coverage, access to health care services through coverage provided to a pregnant *member's* unborn child, or medically needed coverage;
2. A *qualified individual* gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order. In the case of marriage, at least one *spouse* must demonstrate having *minimum essential coverage* as described in 26 CFR 1.5000A-1(b) for one or more days during the 60 calendar days preceding the date of marriage;
3. A *qualified individual* or *dependent member*, who was not previously a citizen, national, or lawfully present individual gains such status; or who is no longer incarcerated or whose incarceration is pending the disposition of charges;
4. A *qualified individual's* enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or its instrumentalities as evaluated and are determined by the Health Insurance Marketplace;
5. A *member* or *dependent member* adequately demonstrates to the Health Insurance Marketplace that the plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the *member*;
6. A *qualified individual*, or *dependent member*, adequately demonstrates to the Health Insurance Marketplace that a material error related to plan benefits, *service area*, or premium influenced the *qualified individual's* or *member's* decision to purchase the *QHP*;
7. A *member* or *dependent member* enrolled in the same plan has a change in eligibility for *cost sharing reductions*;
8. A *qualified individual* or *dependent member* who is enrolled in an eligible employer-sponsored plan is determined newly eligible for *advance premium tax credits* based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-2(c)(3);
9. A *qualified individual*, *member*, or *dependent member* gains access to new *QHPs* as a result of a permanent move and had *minimum essential coverage* as described in 26 CFR 1.5000A–1(b) for one or more days during the 60 calendar days preceding the date of the permanent move;
10. A *qualified individual* or *dependent member* who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a plan or change from one plan to another one time per month;

11. A *qualified individual* or *member* demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by Health and Human Services (HHS), that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide;
12. A *qualified individual*, *member*, or *dependent member* is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B–2, and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
13. A *qualified individual* or *dependent member* is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 calendar days after the qualifying event; or applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;
14. A *qualified individual* newly gains access to an employer sponsored Individual Coverage Health Reimbursement Arrangement (ICHRA) (as defined in 45 CFR 146.123(b)) or a Qualified Small Employer Health Reimbursement Arrangement (QSHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code);
15. At the option of the Health Insurance Marketplace, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a plan through the Health Insurance Marketplace following termination of enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 155.315;
16. A *qualified individual* or *dependent member* 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
17. A *qualified individual* who was previously ineligible for advance payments of the premium tax credit solely because of a household income below 100 percent of the federal poverty level and who, during the same timeframe, was ineligible for Medicaid because he or she was living in a non-Medicaid expansion state, who either experiences a change in household income or moves to a different state resulting in the *qualified individual* becoming newly eligible for advance payments of the premium tax credit.

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

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

To determine if you are eligible and apply for a *special enrollment period*, please visit www.healthcare.gov and search for "*special enrollment period*." The Health Insurance

Marketplace is responsible for all health care eligibility and enrollment decisions for *members* who enrolled via the Marketplace.

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

Coverage Effective Dates for Special Enrollment Periods

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

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

In the case of erroneous enrollment, contract violation, or exceptional circumstances, coverage is effective on an appropriate date based on the circumstances of the *special enrollment period*, in accordance with guidelines issued by the Department of Health and Human Services. Such date must be either:

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

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

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

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

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

1. The *qualified individual* has not been determined eligible for *advance premium tax credit* or *cost sharing reductions*; or
2. The *qualified individual* pays the entire premium for the first partial month of coverage as well as all *cost sharing*, thereby waiving the benefit of *advance premium tax credit* and *cost sharing* 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 *policy* for that *member* until the *member* is discharged from the *hospital* or benefits under the prior coverage are exhausted, whichever is earlier.

If there is no prior coverage or no continuation of *inpatient* coverage after the *effective date*, your Ambetter from Arizona Complete Health coverage will apply for *covered services* related to the *inpatient* coverage after your *effective date*. Ambetter from Arizona Complete Health coverage requires you notify Ambetter from Arizona Complete Health 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 from Arizona Complete Health allowable rate. Please see the Continuity of Care provision in the Access to Care section.

ACCESS TO CARE

Understanding What Is Covered

Each *member* covered under this health plan is entitled to receive the benefits and services described in this *policy*. With the exception of preventive services, all *covered services* must be *medically necessary*. *Covered services* must be obtained from Ambetter from Arizona Complete Health's contracted *network providers*, except for *emergency services* as defined in this *policy*.

Ambetter from Arizona Complete Health reserves the right to modify benefits under this *policy* at any time. Written notice of benefit changes, including modifications to preventive benefits, will be provided to *members* at least 60 calendar days prior to the *effective date* of the change.

Although we encourage you to read this entire document to familiarize yourself with your health coverage, the following sections should be reviewed immediately upon enrollment:

1. ***Prior Authorization***. This section identifies which services and supplies require our review before you receive them in order to receive the maximum reimbursement possible under your health plan.
2. **Major Medical Expense Benefits**. This section describes the services and treatments which are covered under your health plan, including general health physicals.
3. **General Non-Covered Services and Exclusions**. This section identifies services and treatments that are not covered under your health plan or are limited in coverage.

Network Providers

Ambetter from Arizona Complete Health has contracted with *physicians*, *hospitals*, facilities and other *health professionals* to provide *medical services* and treatments to *members* covered under this health plan. These *physicians*, *hospitals* and facilities are referred to as *network providers*.

Your Primary Care Physician (PCP)

Every *member* has the option to have a *PCP*. These *primary care physicians* are sometimes referred to as a *PCP*. Your *PCP* is the person who will provide and coordinate *medical services* and treatments you may require while covered by us. At some time, you may need to see a *physician* who is a *specialist*. Your *PCP* will refer you to one. If you are hospitalized, your *PCP* will coordinate the care and services you need with the *hospital* and any other *physicians* who may be involved.

During regular office hours:

1. Call the office and identify yourself as an Ambetter from Arizona Complete Health *member*.
2. Your *PCP* has a staff that can schedule an appointment or help answer your medical questions.

After regular office hours:

1. Call the office and identify yourself as an Ambetter from Arizona Complete Health *member*.
2. Describe the medical condition you are experiencing.
3. Your *PCP's* office will have your *physician*, or another health professional, contact you. They will discuss the *illness* or *injury* in question and give you direction. Each case is different. You may receive advice over the telephone, or you may be asked to come into the office. In an emergency or urgent situations, you may be directed to the nearest emergency room or *urgent care center*.
4. Always remember that you can call your *PCP's* office 24 hours a day. You do not have to wait for regular office hours to obtain medical advice.

Each member of a family who is covered by us has the right to select their own *PCP*. This means that a parent who desires to have a *PCP* close to their office may select a different *PCP* for their children closer to home. In addition, you may select a *physician* specializing in pediatrics as the *PCP* for each child, even if the pediatric *physician* is not identified as a *PCP*. Please make sure that you have selected a *PCP* for yourself and each of your dependents that are enrolled under this health plan. Until you make this selection, Arizona Complete Health will designate one for you. 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 chose 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.

Refer to our provider directory for a list of *PCPs*, or you can visit our website at AmbetterHealth.com/en/AZ. If you need help in choosing a *PCP*, call Member Services.

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

1. Provide preventive care and screenings.
2. Conduct regular physical examinations as needed.
3. Conduct regular immunizations as needed.
4. Deliver timely service.

5. Work with other doctors when you receive care somewhere else.
6. Coordinate specialty care with *network specialists.*
7. Provide any ongoing care you need.
8. Update your medical record, which includes keeping track of all the care that you get from all of your providers.
9. Treat all patients the same way with dignity and respect.
10. Make sure you can contact him/her or another provider at all times.
11. Discuss what advance directives are and file directives appropriately in your medical record.

Contacting Your Primary Care Physician (PCP)

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

Should you need care outside of your *PCP's* office hours, you should call your *PCP's* office for information on receiving after hours care in your area. If you have an urgent medical problem or question or cannot reach your *PCP* during normal office hours, call our 24/7 nurse advice line at 1-888-926-5057 (TTY: 711). A licensed nurse is always available and ready to answer your health questions. If you are experiencing an *emergency condition*, call 911 or for a *behavioral health emergency condition*, call 988 or go to the nearest emergency room.

Changing Your Primary Care Physician (PCP)

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

Network Availability

Your *PCP* and other *health professionals* have contracted with us to provide *medical services* and treatments to you. They have contracted either individually, or through a group of providers called a *network*. Your *PCP* is affiliated with our provider *network*, and you may be required to obtain services from *specialists* and other providers who belong to that *network*. If you are unsure whether your *PCP* is affiliated with our provider *network*, check our provider directory or call Member Services.

Your *network* is subject to change. The most current *network* may be found online at our website or by contacting us at the number shown on your *member* identification card. A network may not be available in all areas. If you move to an area where we are not offering access to a *network*, please contact Member Services prior to moving or as soon as possible.

You may have the opportunity to disenroll from coverage under this health plan and enroll in a different health plan with a *network* in that area. **Note:** Services received from *non-network providers* are generally not *covered services* under this health plan, except when *balance billing protections* apply to a *covered service* provided by a *non-network provider*. If you receive *covered services* from *non-network providers* that are not subject to *balance billing protections*, benefits will be calculated in accordance with the terms of this *policy* for *non-network providers*.

Specialist Physicians

Specialist physicians are also part of our *network*. If your *PCP* determines that you need care from a *specialist*, your *PCP* will refer you to the appropriate *specialist* within our *network*.

Services and treatments by *specialists* outside our *network* are covered only when a referral is approved. Always remember that your *PCP* is the person responsible for coordinating your care and will refer you to an appropriate *specialist* when it is *medically necessary*. We do allow a few exceptions to the referral requirements, as described in the Medical Expense Benefits section of this *policy*.

You are not required to obtain a referral from a *PCP* or us to obtain *covered services* from a *specialist* within the *network*. We recommend that you work with your *PCP* to determine which *specialist* is right for you. Your *PCP* knows your medical history best and is the most appropriate person to help coordinate all of your health care needs.

Self-referrals under this health plan are limited to *network specialists*. Services received from a *non-network provider* may be denied by us and you may be held financially responsible for the charges.

Availability of Providers

We cannot guarantee the continued availability of any particular *physician*, *network*, facility or other *health professional*. Consequently, if a *PCP* terminates their relationship with us, you will be required to select another *PCP*, who will be responsible for providing and coordinating your total health care. In most cases, *covered services* must be obtained from *network providers* who are under contract with us at the time *medical services* are received.

What to Do in an Emergency

If you experience an *emergency condition*, you should call 911 or for a *behavioral health emergency condition*, call 988 or go to the nearest emergency room.

Some examples of emergencies include:

1. Acute chest pain
2. Severe burns
3. Profuse bleeding
4. Suspected poisoning
5. Severe allergic reaction

Please refer to the Major Medical Expense Benefits section of this *policy* for a complete definition of *emergency services*. This section will also tell you what is covered and what your responsibility is to notify us of an emergency situation.

Urgent Care Situations

Urgent care situations include cases of high fevers, severe vomiting, sprains, fractures, or other *injuries*. In such cases, call your *PCP*. The *PCP's* office is available 24 hours a day, seven days a week by telephone. You will be given direction on how to obtain care for your condition. All follow-up and continuing care must be provided or arranged through your *PCP* in order to be covered by us.

Emergency Services Outside of the Service Area

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

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

Non-Emergency Services

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

Hospital Based Providers

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

New Technology

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

Sometimes, our medical director and/or medical management staff will identify technological advances that could benefit on behalf of our *members*. The Clinical Policy Committee (CPC)

reviews the technological requests from the health plan for coverage and decides whether we should change any of our benefits to include the new technology.

If the CPC does not review a technological request from the health plan 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 from Arizona Complete Health will provide access to third-party services at preferred or discounted rates. The preferred or discounted rates to these services may be communicated to all *members* by email, mail or phone promotions. The preferred partnerships are optional benefits to all *members*.

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 benefits are terminated because of a change in the terms of the participation of the provider, as it pertains to the services the *member* is receiving as a continuing care patient, then we will:

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

Under state law, if a *member* is a *continuing care patient* and is a new *member* whose provider is not a *network provider*, upon written request of the *member* to the plan, we will allow the *member* to continue an active course of treatment with the provider during a transitional period after the *effective date* of enrollment, if the following apply:

1. The *member* has either:
    a. A life-threatening disease or condition, in which case the transition period is not more than 30 days after the *effective date* of enrollment.

b. Entered the third trimester of pregnancy on the *effective date* of the enrollment, in which case the transitional period includes the delivery, and any care related to the delivery that is up to six weeks after the delivery.

2. The *member's non-network provider* agrees in writing to do all of the following:

   a. Except for the *member's* c*opayment, coinsurance*, or *deductible amounts*, accept as payment in full reimbursement at the rates established by us that are not more than the level of reimbursement applicable to similar services by health care providers within our provider *network*.

   b. Comply with our quality assurance and *utilization review* requirements and provide us any necessary medical information related to the *member's* care.

   c. Comply with our policies and procedures pursuant to state law, including those related to *referrals*, obtaining *prior authorization*, claims handling, and treatment plan approval by us.

PREMIUM PAYMENTS

Premium Payments

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

We will notify you 31 calendar days in advance of any rate changes, subject to all regulatory requirements. Notices under this provision will be mailed to the *member's* address of record. We also reserve the right to modify or amend this *policy* and will provide 60 calendar day advance notice to *members* before the *effective date* of any material modification. Receipt of premium payments made by the *member* shall constitute acceptance of the modification or amendment.

Grace Period

The *member's* failure to make premium payment prior to expiration of the grace period defined herein shall be cause for automatic termination of coverage under this *policy*. The date of termination will be the last day of the month for which premium payments have been received in full and accepted by our Accounts Receivable Department.

When a *member* is receiving a premium subsidy:

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

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

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

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

member during the grace period. We will notify the *member*, as well as providers, of the possibility of denied claims when the *member* is in the grace period.

Return of Premium for Ineligible Enrollees

If Ambetter from Arizona Complete Health receives a premium for an individual or a *member's* family member whom Ambetter from Arizona Complete Health determines does not satisfy the eligibility and enrollment requirements, we will refund those amounts applicable to the ineligible enrollee back to the original method of payment and/or payee. Ineligible enrollees are not *members* of this health plan and shall have no right to *covered services* under this *policy*.

Third-Party Payment of Premiums or Cost Sharing

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

1. Ryan White HIV/AIDS Program under Title XXVI of the Public Health Services Act;
2. Indian tribes, tribal organizations or urban Indian organizations;
3. State and federal government programs;
4. Family members;
5. Certain tax-exempt organizations; the IRS Tax Exempt Organization Search (TEOS) tool can be utilized to verify tax-exempt status.
6. An employer for an employee under an Individual Coverage Health Reimbursement Account (ICHRA) or Qualified Small Employer Health Reimbursement Account (QSEHRA) plan; or
7. Private, not-for-profit foundations which have no incentive for financial relationship, or affiliation with providers of *covered services* and supplies on behalf of *members*, where eligibility is determined based on defined criteria without regard to health status and where payments are made in advance for a coverage period from the *effective date* of eligibility through the remainder of the *calendar year*.

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

Renewal

Subject to the provisions governing payment of premiums, this *policy* shall automatically renew for which premiums are being made.

With the exception of non-payment of premium or *loss* of eligibility, if we decide to terminate or non-renew this *policy* for any of the reasons set forth in this *policy*, we will give the *member* at least 45 calendar days advance written notice prior to renewal.

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 Federally Facilitated Marketplace (**Note:** non-Health Insurance Marketplace plans must notify us directly) of your new residence within 60 calendar days of the change. As a result, your premium may change, and you may be eligible for a *special enrollment period*. See the Special Enrollment Periods provision for more information.

Misstatement of Tobacco or Nicotine Use

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

COST SHARING FEATURES

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

When you, or a covered *dependent 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*.

Individual and Family Deductibles

The individual and family *calendar year deductible amounts* are shown in the *Schedule of Benefits*. The *calendar year deductible* applies to the medical and *outpatient prescription drug* benefits. Once your payment for medical and *outpatient prescription drug covered services* equals the *deductible amount*, the medical and *outpatient prescription drug* benefits will become payable by us, subject to any additional *copayment* or *coinsurance* as described in the *Schedule of Benefits*.

Each *member* must satisfy the individual *deductible* each year, if the family *deductible* has not been previously satisfied in that year, before benefits are payable by us. Once the family *deductible* is met, no further individual *deductible* for members of the family unit will have to be satisfied during the year for benefits to be payable by us. Any exceptions will be shown in the *Schedule of Benefits*. All amounts applied toward the individual *deductible* for each *member* in a family unit will accumulate to satisfy the family *deductible*. Once the family *deductible* is met, no further individual *deductibles* for covered *members* in the family unit will have to be satisfied during the *calendar year*.

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

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

The *deductible amount* does not include any *copayment amounts*. Not all services are subject to the *deductible*.

Coinsurance

A *coinsurance amount* is your share of the cost of a service. *Members* may be required to pay a provider *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*.

Copayments

A *copayment amount* is your share of the cost of a service. *Members* may be required to pay a *copayment* up front for a *covered service* or supply. *Copayment amounts* do not apply toward the *deductible* but do apply toward your *maximum out-of-pocket amount*.

Maximum Out-of-Pocket

This is the total dollar amount that a *member* or family unit is required to pay for *covered services* during any given *calendar year*. 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*. *Maximum out-of-pocket amounts* are determined for *covered services* only and do not apply to any *medical services* or treatments that are not *covered services*. After the *maximum out-of-pocket amount* is met for an individual, Ambetter from Arizona Complete Health from Arizona pays 100 percent of *covered services* for that individual. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket amount*. Both the individual and the family *maximum out-of-pocket amounts* are shown in the *Schedule of Benefits*.

For family coverage, the family *maximum out-of-pocket amount* can be met with the combination of any *member's eligible expense*. 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 *members*, you will satisfy your *maximum out-of-pocket amount* when 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 following are not counted toward the individual or family *maximum out-of-pocket amounts* and will not be paid at 100 percent once the *maximum out-of-pocket amount* is met. They will be subject to the *copayment, coinsurance* and/or *deductible* as shown in the *Schedule of Benefits*:

1. Any percentage of *eligible expenses* that a *member* must pay due to failure to follow any requirements of *prior authorization*.
2. Limitations and exclusions.

Refer to your *Schedule of Benefits* for *cost sharing* responsibility and other limitations.

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*.

Non-Network Liability and Balance Billing

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

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

Adjusted Claim Impacts to Member Cost Share Responsibility

Some Explanation of Benefits (EOBs) will show that a “claim payment adjustment” has occurred. Claim payment adjustments may look like claims were paid, then taken back, and possibly paid differently. Sometimes these payment adjustments appear multiple times in the same EOB. Claims payment adjustments can be at the request of the billing provider or initiated by us to ensure correct payments for *covered services*.

When adjusted claims are reflected in your EOB, they can change your *cost sharing* responsibility or impact your *maximum out-of-pocket*. You can track what you have paid towards your *maximum out-of-pocket* through our secure online *member* account at AmbetterHealth.com/en/AZ or call Member Services with any questions about your *cost share* amounts.

UTILIZATION MANAGEMENT

Please read this entire provision carefully. If you are unsure whether a service or treatment requires *prior authorization*, please call Ambetter from Arizona Complete Health or have your provider call Ambetter from Arizona Complete Health for additional information.

Selected medical and *behavioral health* services and treatments that are covered under your health plan require *authorization* before you receive them in order for them to be covered by us. This *authorization* is referred to as *prior authorization*. This means that even though a service or treatment may be a *covered service*, *prior authorization* must be obtained before the service or treatment can be received. It is the responsibility of *network providers* to request and obtain *prior authorization*, when applicable. Even those services that are determined to be *medically necessary* by us must have *authorization* in order to be covered. *Physicians* and *networks* cannot deny a service or treatment for failure to obtain *authorization*. Only we can deny coverage for *medical services* for failure to obtain *authorization*. Questions concerning *authorization* can be directed to your *PCP*, or you can call Member Services. *Prior authorization* does not guarantee coverage. When Arizona Complete Health provides *prior authorization* for specific care by a provider, we will not rescind or modify the *authorization* after the provider renders the *authorized* care in good faith and pursuant to the *authorization*.

Circumstances in which the service will not be covered include, but are not limited to:

1. Other plan provisions are not satisfied (for example, the *member* is not enrolled or eligible for service on the date the service is received, or the service is not a *covered service*);
2. Fraudulent, materially erroneous or incomplete information is submitted; or
3. A material change in the *member's* health condition occurs between the date that the *authorization* was provided and the date of the treatment that makes the proposed treatment no longer *medically necessary* for such *member*.

In the event that we certify the *medical necessity* of a course of treatment limited by number, time period or otherwise, a request for treatment beyond the certified course of treatment shall be deemed to be a new request.

As a general rule, please remember that, except for *emergency services*, all *medical services* and treatments must be provided through the direct coordination of the *PCP* and received within the *service area*. If they are not, your *policy* may not cover these services.

Authorization Requirements

The following services or supplies may require *prior authorization*:

1. *Hospital* confinements
2. *Hospital* confinement as the result of a medical emergency
3. *Hospital* confinement for psychiatric care

4. *Outpatient* surgeries and major diagnostic tests
5. All *inpatient* services
6. *Extended care facility* confinements
7. *Rehabilitation* facility confinements
8. *Skilled nursing facility* confinements
9. Transplants
10. Chemotherapy, specialty drugs and biotech medications

For a list of services that require *prior authorization*, please refer to the "Provider Resources" page located on AmbetterHealth.com/en/AZ.

Prior authorization (medical and *behavioral health*) requests should be submitted for *medical necessity* review as soon as the need for services are identified. Requests must be received by telephone, fax, or provider web portal. Faxed requests must be submitted by providers using the state required Department of Insurance and Financial Institutions form, or we are not able to review the request.

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

1. For urgent concurrent reviews, received at least 24 hours prior to the expiration of a previously approved course of treatment, within 24 hours of receipt of the request. For all other urgent concurrent reviews, within 72 hours of receipt of request.
2. For urgent pre-service reviews, within 3 calendar days from date of receipt of request.
3. For non-urgent pre-service requests, within 14 calendar days of receipt of the request.
4. For post-service requests, within 30 calendar days of receipt of the request.

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

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

How to Obtain Prior Authorization

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

Failure to Obtain Prior Authorization

Failure from the *network provider* to comply with the *prior authorization* requirements will result in benefits being reduced or denied.

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*.

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*.

An *authorization* request, once granted or deemed granted, is binding and may be relied on by the *member* and provider and may not be rescinded or modified by us after the provider renders the *authorized* health care services in good faith and pursuant to the *authorization* unless there is evidence of fraud or misrepresentation by the provider. A *prior authorization* request is deemed granted if we fail to comply with the deadlines and notification requirements. If a claim has been denied for no *authorization*, and *authorization* was obtained, your provider can submit a request for *post-service claim* dispute resolution review.

Authorization Denials

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

Services from Non-Network Providers

Except when *balance billing protections* apply to a *covered service* provided by a *non-network provider*, we do not normally cover services received from *non-network providers*. If a situation arises where a *covered service* cannot be obtained from a *network provider* located within a reasonable distance, we may provide a *prior authorization* for you to obtain the service from a *non-network provider* at no greater cost to you than if you went to a *network provider*. If *covered services* are not available from a *network provider*, your *PCP* is responsible for requesting *prior authorization* from us before you receive services from a *non-network provider*. Otherwise, you will be responsible for all charges incurred.

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

Utilization Review

Ambetter from Arizona Complete Health reviews certain requests for medical procedures, specialty consultations and hospitalizations to determine whether the treatment is *medically necessary*, as determined by us, and to verify that the services are covered under this *policy*. The determination of the reviewer or professional review organization is not a substitute for the independent judgment of the treating *physician* as to the course of treatment. *Utilization*

management decisions do not prevent treatment or hospitalization but do determine whether or how the treatment or hospitalization is covered by us.

MAJOR MEDICAL EXPENSE BENEFITS

Essential health benefits are defined by federal and state law and refer to benefits in 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. Certain non-essential health benefits, however, are subject to either a lifetime and/or annual dollar maximum. Coverage is limited to essential health benefits and other benefits as required under *applicable laws*. Services that are not essential health benefits and are not otherwise required to be covered under *applicable laws,* are not covered under this *policy***.**

Covered services must be furnished in connection with diagnosis that demonstrates *medical necessity* and treatment of an *illness* or *injury* (other than *eligible expenses* for preventive care services, if applicable). If we determine that a service or supply or medication is not *medically necessary*, you will be responsible for payment of that service, supply or medication.

Covered services are subject to the *deductible*, *copayment* and/or *coinsurance amounts*, maximum benefits per year, and other limitations as described in your *Schedule of Benefits*, and to all other provisions of this *policy*.

Coverage under the *policy* is limited to the most effective and efficient level of care and type of service supply or medication that is consistent with professionally recognized standards of medical practice, as determined by us.

How Eligible Expenses are Determined

Ambetter from Arizona Complete Health will pay for *eligible expenses* you incur under this *policy*. As described below, *eligible expenses* are based on the amount we will allow for *covered services* you receive from each type of provider, not necessarily the amount a *physician* or other provider bills for the service or supply. Other limitations on *eligible expenses* may apply. See the Major Medical Expense Benefits and the General Non-Covered Services and Exclusions sections of this *policy* as well as your *Schedule of Benefits* for specific benefit limitations, maximums, *prior authorization* requirements and surgery payment policies that limit the amount we pay for certain *covered services*.

Acquired Brain Injury Services

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

1. Cognitive *rehabilitation therapy*;
2. Cognitive communication therapy;
3. Neurocognitive therapy and *rehabilitation*;

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

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

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

Ambulance Service Benefits

Air Ambulance Benefits

Covered services will include ambulance services for transportation by fixed wing and rotary wing air transportation from home, scene of accident, or *emergency condition*:

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

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

Limitations:

Benefits for air ambulance services are limited to:

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

Exclusions:

No benefits will be paid for:

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

Ground and Water Ambulance Benefits

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

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

Note: Non-emergency ambulance transportation requires *prior authorization*. Unless otherwise required by federal or state law, if you receive services from non-network ambulance providers, and services are not *prior authorized* or emergent, you may be *balance billed*.

Exclusions:

No benefits will be paid for:

1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by *applicable law*.
2. Non-emergency ground or water ambulance unless *prior authorization* is approved before services are rendered to the *member*.
3. Ambulance services provided for a *member's* comfort or convenience.
4. Non-emergency transportation (for example, transport van, taxi, ride sharing).

Autism Spectrum Disorder Benefits

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

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.
9. Medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.
10. Short-term *rehabilitation therapy.*

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

Bariatric Surgery and Related Covered Services

Covered services include *inpatient* bariatric surgery and gastric bypass surgery, including lap banding adjustments, for the treatment of morbid obesity that are *medically necessary* and not *experimental* or *investigational*. These *covered services* must be *authorized* by us in accordance with our evidence-based criteria for this intervention contained in our medical *policy* on bariatric surgery which can be found at AmbetterHealth.com/en/AZ under the medical policies link.

In addition, the following criteria must be met:

1. The patient must have a body-mass index (BMI) ≥35.
2. Have at least one co-morbidity related to obesity.
3. Previously unsuccessful with medical treatment for obesity.

The following medical information must be documented in the patient's medical record:

1. Active participation within the last two years in one *physician* supervised weight-management program for a minimum of six months without significant gaps.
2. The weight-management program must include monthly documentation of all of the following components:
    a. Weight
    b. Current dietary program
    c. Physical activity (e.g., exercise program)

We apply evidence-based medicine, and in as much develops national medical policies to define *medical necessity*. At a minimum, the following procedures are included: laparoscopic sleeve gastrectomy (LSG), open Roux-en-Y Gastric Bypass (RYGBP), Laparoscopic Adjustable Gastric Banding (LAGB), open biliopancreatic diversion with duodenal switch (BPD/DS) and laparoscopic biliopancreatic diversion with duodenal switch (BDP/DS).

Surgery will be considered *medically necessary* for adolescent ages 13 to 18 years of age when criteria are met.

In addition, the procedure must be performed at a *network* facility.

Biofeedback Services

Biofeedback is a *covered service* when prescribed for pain management only.

Care Management Programs

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

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

If you think you could benefit from our *Care Management* program, which are optional benefits available to all *members*, please call Member Services.

Chiropractic Services

Members may self-refer to a contracted chiropractor. We cover *medically necessary* chiropractic care provided on an *outpatient* basis. See the *Schedule of Benefits* for applicable *cost share* and limits.

Covered services are those within the scope of chiropractic care which are necessary to help *members* achieve the physical state enjoyed before an *illness* or *injury*, and which are determined to be *medically necessary* and generally furnished for the diagnosis and/or treatment of neuromusculoskeletal conditions associated with an *injury* or *illness*, including:

1. Chiropractic manipulations, adjustments and physiotherapy
2. Diagnostic radiological services generally provided by *network* chiropractors
3. Examination and treatment for the aggravation of an *illness* or *injury*
4. Examination and treatment for the exacerbation of an *illness* or *injury*

Chronic Disease Self-Management Training

Chronic disease self-management training from a *network physician* is covered when it has a therapeutic role in the care of a diagnosed chronic disease/condition, including, but not limited to:

1. Morbid obesity
2. Diabetes
3. Cardiovascular disease
4. Hypertension
5. Kidney disease
6. Eating disorders
7. Gastrointestinal disorders
8. Food allergies
9. Hyperlipidemia

Clinical Trial Coverage

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

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

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

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

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

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

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

For more information about NIH clinical research trials, please visit https://www.nih.gov/health-information/nih-clinical-research-trials-you

The following items listed do not apply to phase III or IV FDA clinical trials:

1. 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; or
    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;

iii. Not an unproven service.

d. It has FDA approval, but is being used for a use, or to treat a condition, 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*;

2. *Experimental* or *investigational* according to the provider's research protocols.

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*.

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 Arizona Complete Health upon request.

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

Diabetic Care Management

The following is covered in relation to *members* who have been diagnosed with gestational, type I, or type II diabetes:

1. Diabetes *outpatient* self-management training and education, including a wellness health coaching program that guides an individual to change unhealthy behaviors and adopt positive lifestyle changes in order to promote the life-long practice of good health behavior. Refer to the *Schedule of Benefits* for applicable c*opayment, coinsurance* or *deductibles*.
2. Supplies and equipment related to diabetes management as described in the Outpatient Prescription Drug Benefit and Diabetic Equipment, Supplies and Devices provisions of this *policy*.
3. Nutritional counseling services are covered and not subject to the lifetime limit.
4. Routine foot care; *prior authorization* may be required.

Diabetic Equipment, Supplies and Devices

Diabetic supplies are covered when *medically necessary*. The following are specific requirements for coverage:

1. Diabetic supplies must have a written prescription from a *network provider*, when *medically necessary*.
2. Refills are covered only when *authorized* by a *network provider*, when *medically necessary*.

3. Covered supplies and equipment must be obtained from a *network provider* unless otherwise *authorized* by us.
4. Plan approved standard blood glucose monitors are covered for both insulin-dependent *member* and non-insulin *dependent members* when necessary for medical management as determined by us in consultation with your *physician*. Blood glucose monitors require a written prescription from a *physician* and must be obtained at a *network* pharmacy.
5. Plan approved blood glucose monitors for the legally blind are covered when *medically necessary* and the *member* has been diagnosed with diabetes. Blood glucose monitors require a written prescription from a *physician* and must be obtained at a *network* pharmacy.

The following are examples of diabetic supplies that are covered when they meet the specific requirements for coverage:

1. Glucose test strips
2. Visual reading testing strips
3. Urine testing strips
4. Insulin aids (when *medically necessary*)
5. Glucagon
6. Drawing up devices (syringes) and monitors for the visually impaired
7. Preferred insulin vials/pens
8. Insulin cartridges for both the legally blind and the able seeing; requires *prior authorization*
9. Insulin and insulin pumps (The total amount you will be required to pay for a covered insulin drug will not exceed any state and/or federal mandated limits.)
10. Lancets and automatic lancing devices
11. Spacers and holding chambers for inhaled medications
12. Inhalers (nasal or oral)
13. Injection aids

The following diabetic equipment is covered under the *durable medical equipment* benefit:

1. Podiatric appliances necessitated by a diabetic condition
2. Foot orthotics.

Dialysis Services

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

Covered services include:

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

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

Disposable Medical Supplies

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

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

The supplies, equipment and appliances described below are *covered services* under this benefit. All types of *durable medical equipment* and supplies are subject to *prior authorization* as outlined in this *policy*. Please see your *Schedule of Benefits* for benefit levels or additional limits. 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:

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.

The rental or 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. Standard hospital beds
4. Standard walker
5. Standard non-motorized wheelchair and wheelchair cushion
6. Ventilators
7. One Continuous Passive Motion (CPM) machine per *member* following a covered joint surgery
8. *Medically necessary* foot orthotics
9. The cost of a monofocal lens, if the multifocal lens is implanted after a cataract extraction
10. Pressure machines

11. Infusion pump for I.V. fluids and medicine for infusion therapy
12. Glucometer
13. Tracheotomy tube
14. Cardiac, neonatal and sleep apnea monitors
15. Augmentative communication devices are covered when we approve based on the *member's* condition.

Exclusions:

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

1. Air conditioners
2. Ice bags/coldpack pump
3. Raised toilet seats
4. Rental of equipment if the *member* is in a facility that is expected to provide such equipment
5. Translift chairs
6. Treadmill exerciser
7. Tub chair used in shower
8. Penile prosthesis when *medical necessity* criteria are not met or is strictly a cosmetic procedure.

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

Internal *prosthetic*/medical appliances are *prosthetics* and appliances that are permanent or temporary internal aids and supports for missing or nonfunctional body parts, including testicular implants following medically appropriate surgical removal of the testicles are covered. Medically appropriate repair, *maintenance* or replacement of a covered appliance is covered.

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

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

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

Covered services may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per benefit period, as required by the Women's Health and Cancer Rights Act. Maximums for *prosthetic devices*, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.

5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are *covered services*. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session.) Eyeglasses (for example bifocals), including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or *injury*; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses and are not considered the first lens following surgery. If the *injury* is to one eye or if cataracts are removed from only one eye and the *member* selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Cochlear implant and bone anchored hearing aids.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (not to exceed one per calendar year), when purchased through a *network provider*.

Exclusions:

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

1. Dentures, replacing teeth or structures directly supporting teeth
2. Dental appliances
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets
4. Artificial heart implants
5. Repairs and/or replacement of parts or devices worn out due to misuse or abuse
6. Model upgrades
7. Custom breast prosthesis
8. Any biomechanical devices. Biomechanical devices are any external *prosthetics* operated through or in conjunction with nerve conduction or other electrical impulses.

Orthotic devices

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

Covered *orthotic devices* that are *medically necessary* may include, but are not limited to:

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

Exclusions:

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

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

Emergency Services

If you experience an *emergency condition*, you should call 911 or for a *behavioral health emergency condition*, call 988 or go to the nearest emergency room. We cover *emergency services* both in and out of our *service area*. We cover these services 24 hours a day, 7 days a week.

***Emergency services* do not include use of a *hospital* emergency room or other emergency medical facility for routine *medical services*, or follow-up or continuing care. The *member* will be financially responsible for any emergency room expenses for any non-emergency services as determined by Ambetter from Arizona Complete Health.**

Emergency services:

1. Do not require *prior authorization*.
2. Include an initial medical or psychiatric screening examination and any immediate treatments or services to *stabilize* a condition. Additional treatments or services may be retrospectively reviewed for *medical necessity*.
3. Require the *member* to notify the *PCP* within 48 hours after *emergency services* are provided by a *non-network provider*, or as soon thereafter as is medically possible. If admitted to a non-contracted *inpatient* facility, we may transfer the *member* to a *network hospital* for continued care if it is medically appropriate.

4. Require the *member* to provide full details, including medical or psychiatric records of *emergency services* rendered by a *non-network provider*, if requested by this health plan. Costs associated with *emergency services* will be reimbursed only after we receive and review the emergency medical or psychiatric records and determine that such services were *medically necessary*.

Family Planning Services (Contraception and Voluntary Sterilization)

Family planning and contraception services are covered under preventive care, without *cost sharing*, when received from a *network provider* and when the care is legal under *applicable law*. This coverage 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 U.S. Food and Drug Administration (FDA) including:
   a. Sterilization surgery for women,
   b. Implantable rods,
   c. Copper intrauterine devices,
   d. Intrauterine devices with progestin (all durations and doses),
   e. Injectable contraceptives,
   f. Oral contraceptives (combined pill),
   g. Oral contraceptives (progestin only),
   h. Oral contraceptives (extended or continuous use),
   i. The contraceptive patch,
   j. Vaginal contraceptive rings,
   k. Diaphragms,
   l. Contraceptive sponges,
   m. Cervical caps,
   n. Condoms,
   o. Spermicides,
   p. Emergency contraception (levonorgestrel), and
   q. Emergency contraception (ulipristal acetate).
2. Coverage is also available for any additional contraceptives approved, granted, or cleared by the FDA (if the patient and the patient's attending provider have determined it to be medically appropriate).

3. Contraceptive care, such as screening, education, provision of contraception, counseling and follow-up care (e.g., management, evaluation and changes, including the removal, continuation and discontinuation of contraceptives).
4. Instruction in fertility awareness-based methods, including lactation amenorrhea.

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

Refer to the *Schedule of Benefits* and the Outpatient Prescription Drug Benefit section of this *policy*, and at the following website: fda.gov/consumers/womens-health-topics/birth-control.

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.

Exclusions and Limitations: Services and supplies for gamete or embryo storage, use of frozen gamete or embryos to achieve future conception, pre-implantation genetic diagnosis, donor egg, sperm or embryos and/or gestational carriers.

Genetic Testing

Diagnostic genetic testing is covered for purposes of diagnosis, treatment, appropriate management or ongoing monitoring of *member's* disease or condition to guide treatment decisions when testing has been approved and/or nationally recognized.

Genetic testing, amniocentesis, ultrasound, or any other procedure required solely for the purposes of determining the sex of a fetus is not covered.

Sterilization Procedures

Sterilization procedures, including tubal ligation and vasectomy are covered. *Copayment* and/or *coinsurance* will correspond to the charge associated with the facility in which services are received. Preventive sterilization of *members* is covered under the Preventive Care benefit, subject to the applicable *copayment* and/or *coinsurance* listed in the *Schedule of Benefits*.

Note: If you are enrolled in a high *deductible* health plan (HDHP) that is HSA-eligible, *deductible* and *cost share* will apply to sterilization procedures unless it is considered a preventive benefit.

Habilitative Services

Coverage for *habilitative services* and/ or therapy is limited to *medically necessary* services that help a person keep, learn, or improve skills and functioning for daily living, when provided by a *network* contracted *physician*, licensed physical, speech or occupational therapist or other *network provider*, acting within the scope of their license, to treat physical and *mental health*

disorder conditions, subject to any required *authorization* from the Ambetter from Arizona Complete Health or the *member's physician* group. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of *inpatient* and/or *outpatient* settings.

Examples of health care services that are not habilitative include, but are not limited to, *respite care*, day care, recreational care, residential treatment, social services, *custodial care*, or education services of any kind, including, but not limited to, vocational training. See your *Schedule of Benefits* for benefit levels and additional limits.

Hearing Services

Covered services include:

1. Hearing screenings to determine the presence of hearing loss and/or to diagnose and treat a suspected disease or *injury* to the ear.
2. Treatment for a disease or *injury* to the ear.
3. Cochlear implants when *medically necessary*.
4. New or replacement hearing aids no longer under warranty (*prior authorization* required).
5. Cleaning or repair.
6. Batteries for cochlear implants and bone anchored hearing aids.

Covered services do not include hearing aid batteries (except those for cochlear implants and bone anchored hearing aids) and chargers are not covered. All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids are not covered.

Home Health Care Services

Covered services and supplies for *home health care* when your *physician* indicates you are not able to travel for appointments in a medical office, includes *medically necessary network* care provided at the *member's* home and includes:

1. *Covered services* must be provided by an Ambetter from Arizona Complete Health contracted *home health care agency*.
2. Coverage is limited to *medically necessary* patient care pursuant to guidelines, frequency, duration and level *authorized* by us.
3. *Covered services* include nursing care under the supervision of a registered nurse and rehabilitative therapy and/or I.V. therapy, when prescribed, *authorized* or directed by the *PCP* and *authorized* by us.
4. *Covered services* are limited to part-time and *intermittent* patient care that is determined to be *medically necessary*.

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

Covered services do not include:

1. Housekeeping services.
2. Services of a person who resides in the *member's* home.
3. *Custodial care*, rest cures, *respite care* and home care that is or can be performed by family members or non-medical personnel.
4. Services of a person who qualifies as a family member.
5. Services of an unlicensed person.

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

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

Hospice Care Services

All *hospice* care must be provided by a licensed *network hospice* and include *inpatient* and home care related to the terminal condition and family counseling. *Hospice* care will continue only while the *member* is under the direct and active medical supervision of a *network physician* for a condition that necessitates *hospice* care. Benefits for *hospice inpatient*, home and *outpatient services* are subject to *prior authorization* as outlined in this *policy*.

Hospice care providers must be able to provide:

1. Licensed nursing care.
2. Medical supplies.
3. Medications.
4. *Physician* services.
5. Short-term *inpatient care.*
6. Medical appliances.
7. Care for acute and chronic symptom management.
8. Care for pain control.
9. Physical and/or respiratory therapy.
10. Medical social services.
11. Home health services.
12. Services of volunteers.

13. Services of a psychologist, social worker or family counselor for individual and family counseling.

A *member* who elects *hospice* care is not entitled to services and supplies for curative or life prolonging procedures during the time that the *hospice* election is in effect. A *member* may revoke a *hospice* election at any time.

Hospital Services

Emergency services* and the minimum *hospital* stay requirements for maternity delivery do not require *prior authorization. All other *inpatient hospital* services must be *prior authorized*.

Note: Additional services (including but not limited to x-rays and/or lab testing services) that are performed within a *hospital* setting may be subject to *balance billing* in accordance with the *Schedule of Benefits*. *Eligible expenses* for preventive care services do not require *member cost sharing*.

Additionally, 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 the provider's *billed amount*.

Any *member* who receives *emergency services* must contact their *PCP* within 48 hours of admission, or as soon thereafter as is reasonably possible.

Inpatient Services

Covered services include:

1. Semiprivate room and board (private room when *medically necessary*).
2. *Hospital* and *physician* services, including supplies and consultation.
3. ICU, CCU and other special care units.
4. Operating room and related facilities.
5. Medications and biologicals.
6. Diagnostic services, including x-ray and laboratory.
7. General nursing care (special duty nursing when *medically necessary* and *authorized*).
8. Oxygen and related services.
9. Inhalation treatment.
10. *Private duty nursing* is provided under the direction of a *physician*-signed order, specific to an individualized plan of care implemented by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). It does not include non-skilled care, *custodial care*, *respite care*, or care during surgical procedures, including anesthesia.
11. Surgical procedures, including anesthesia.
12. Meals, including special diets when *medically necessary.*

13. Administration of whole blood and blood plasma.
14. *Physician* visits.
15. Radiation therapy and chemotherapy.
16. Physical therapy, speech therapy, occupational therapy and cardiac and pulmonary *rehabilitation.*
17. *Medically necessary* services of a *physician* who renders services in a *network urgent care center*, including office visits and consultations, *hospital* and *skilled nursing facility* visits, and visits to your home.

All covered surgical procedures, including the services of the surgeon or *specialist*, assistant surgeon and anesthetist or anesthesiologist, together with preoperative and postoperative care are covered.

Surgery includes surgical reconstruction of a breast incident to a mastectomy, including surgery to restore symmetry; it also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema and at least four external postoperative *prostheses*, including mastectomy bras/camisoles, subject to all of the terms and conditions of the *policy*.

Payment of benefits for surgical expenses will be reduced as set forth herein if *prior authorization* is not obtained for the surgery.

All *inpatient* services including ancillary services are subject to Arizona Complete Health *medical necessity* reviews, including *prior authorization*, concurrent and post service payment reviews. Any service or payment denials will include *health care appeal* and *grievance* process and contact information.

Outpatient Services Including Ambulatory Surgical Facilities

Covered services include:

1. Medications and biologicals.
2. Surgical procedures, including anesthesia.
3. Therapeutic services including chemotherapy, radiation therapy and inhalation treatment.
4. Diagnostic services, including x-ray, laboratory, and biomarker testing (which is not subject to *medical necessity*), for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of a *member's* disease or condition to guide treatment decisions when testing has been approved and/or nationally recognized.
5. Oxygen and related services.
6. *Emergency services* as defined in this *policy.*
7. Administration of whole blood and blood plasma.
8. Physical therapy, speech therapy, occupational therapy, cardiac and pulmonary *rehabilitation.*

9. Services related to diagnosis, treatment and appropriate management of osteoporosis when such services are provided by a person licensed to practice medicine and surgery in the state, if the *member* has a condition or medical history for which bone mass measurement is medically indicated.
10. *Medically necessary* routine foot care; *prior authorization* may be required.

All *outpatient* services, including ancillary services, are subject to *medical necessity* reviews, including *prior authorization* and post service payment reviews. Any service or payment denials will include *health care appeal* and *grievance* process and contact information.

Infertility Services

Services associated with infertility are limited to diagnostic services rendered for infertility evaluation. Refer to the General Non-Covered Services and Exclusions section of this *policy* for more detail on non-covered infertility services. Services to treat the underlying medical conditions that cause infertility are covered (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).

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, when *medically necessary* and approved by us. LTACH benefits are subject to *prior authorization* requirements as outlined in this *policy*.

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

1. Complex wound care:
    a. Daily *physician* monitoring of wound
    b. Wound requiring frequent complicated dressing changes, and possible repeated debridement of necrotic tissue
    c. Large wound with possible delayed closure, draining, and/or tunneling or high output fistulas
    d. Lower extremity wound with severe ischemia
    e. Skin flaps and grafts requiring frequent monitoring
2. Infectious disease:
    a. Parenteral anti-infective agent(s) with adjustments in dose
    b. Intensive sepsis management
    c. Common conditions include osteomyelitis, cellulitis, bacteremia, endocarditis, peritonitis, meningitis/encephalitis, abscess and wound infections
3. Medical complexity:

a. Primary condition and at least two other actively treated co-morbid conditions that require monitoring and treatment
b. Common conditions include metabolic disorders, stroke, heart failure, renal insufficiency, necrotizing pancreatitis, emphysema (COPD), peripheral vascular disease, and malignant/end-stage disease

4. *Rehabilitation*:
   a. Care needs cannot be met in a *rehabilitation* or *skilled nursing facility.*
   b. Patient has a comorbidity requiring acute care.
   c. Patient is able to participate in a goal-oriented *rehabilitation* plan of care.
   d. Common conditions include CNS conditions with functional limitations, debilitation, amputation, cardiac disease, and orthopedic surgery.
5. Mechanical ventilator support:
   a. Failed weaning attempts at an acute care facility.
   b. Patient has received mechanical ventilation for 21 consecutive days for six hours or more/per day.
   c. Ventilator management required at least every four hours as well as appropriate diagnostic services and assessments.
   d. Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions.
   e. Patient is hemodynamically stable and not dependent on vasopressors.
   f. Respiratory status is stable with maximum PEEP requirement 10 cm H2O, and FiO2 60% or less with O2 saturation at least 90%.
   g. Common conditions include complications of acute lung *injury*, disorders of the central nervous and neuromuscular systems, and cardiovascular, respiratory, and pleural/chest wall disorders.
   h. Patient continues to meet the criteria above and does not meet the criteria to be transitioned to alternate level of care.

Lymphedema Benefit

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

Mammography

Covered services for a *member* will include mammography screenings that align with USPSTF A and B rated guidelines, as well as the HRSA and *applicable laws*. This coverage encompasses *medically necessary* preventive and diagnostic mammograms, digital breast

tomosynthesis, magnetic resonance imaging (MRI), breast ultrasounds, and pathology evaluations to complete the screening process. Per state law, *medically necessary* supplemental breast examinations, diagnostic mammography, diagnostic breast magnetic resonance imaging (MRI), breast ultrasounds, or molecular breast imaging are covered without *member cost share* (i.e., covered in full without *deductible amount, copayment amount* or *coinsurance amount*) when obtained from a *network provider*.

Coverage is available to all *members*, regardless of age, when these services are prescribed by a licensed health care provider acting within their professional scope. For further details on this benefit, please refer to the Preventive Care Guide. It is accessible via our website at AmbetterHealth.com/en/AZ.

Maternity Care Services

Medically necessary services and supplies furnished in connection with pregnancy and childbirth are covered.

Covered services include:

1. Prenatal and post-partum care
2. Birth services, including delivery room, birthing centers, anesthesia and surgical procedures
3. Ultrasound
4. Anesthesia
5. Injectables
6. Special procedures such as cesarean section
7. Prenatal diagnostic procedures in case of high-risk pregnancy or as otherwise *medically necessary*
8. *Complications of pregnancy* as defined in this *policy*
9. X-ray and laboratory services
10. Surgical procedures
11. Breastfeeding support, supplies, and counseling as supported by the Health Resources and Services Administration (HRSA) guidelines, are covered under the Preventive Care benefit listed in the *Schedule of Benefits*
12. Prenatal screenings as outlined in the USPSTF recommendations A&B are covered under the Preventive Care benefit listed in the *Schedule of Benefits*.
13. Diagnostic genetic testing is covered when determined to be *medically necessary* and *authorized* through the *physician* or referring *specialist*
14. Newborn hearing screenings, necessary rescreening, audiological assessment and follow-up, and initial amplification
15. Pulse oximetry screening on a newborn

16. Cost of birth of any legally adopted child within one year of birth if the *member* is legally obligated to pay

Note: To continue coverage after the first 31 calendar days, the newborn must have an enrollment application submitted within 60 calendar days of the date of birth. Failure to enroll a newborn within 60 calendar days following the date of birth will terminate coverage at the end of the initial 31 calendar day period. For continued coverage of the newborn beyond the first 31 calendar days following birth, *members* are required to complete the enrollment process for the newborn by the 60th day of birth. For additional information regarding premium due dates, please reference the Enrollment of Newborn, Adopted Child or Child Placed for Adoption provision of this *policy*. Newborn *members* have 30 calendar days from the date of enrollment to have a *PCP* designated and receive a *member* identification card.

Duty to Cooperate

We do not cover services, supplies, or drugs related to a non-member's pregnancy when a non-member, who is acting as a *surrogate*, has entered into a *surrogacy arrangement*. For more information on excluded services, please see the General Non-Covered Services and Exclusions section. *Members* who are a *surrogate* at the time of enrollment or at any time during the plan year must, within 30 calendar days of enrollment, send us written notice to:

Ambetter from Arizona Complete Health
Member Services
1850 W. Rio Salado Parkway, Suite 211
Tempe, AZ 85281

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

Travel Outside of the Service Area

Expectant *members* who have reached 32 weeks gestation are encouraged to discuss any travel arrangements outside of the *service area* with their *PCP*. Prenatal visits or elective care received outside of Ambetter from Arizona Complete Health's *service area* are not covered unless *authorized* by us. *Emergency services* received outside the *service area* are limited to conditions that require immediate attention.

Minimum Hospital Stay Requirements.

Hospital length of stay for the mother and newborn following a covered delivery will be at the discretion of the treating *physician* in consultation with the child-bearer. *Hospital* benefits for the child-bearer and newborn will not be restricted to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, if ordered by the treating *physician*. Providers will not be required to obtain *prior authorization* for such lengths of stay unless the baby is not a well newborn. These provisions do not prohibit lengths of stay of less than the minimum otherwise required when the attending *physician*, in consultation with the child-bearer, makes a decision for early discharge.

Other maternity benefits which may require *prior authorization* by us 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 beyond the 48 hours following a normal vaginal delivery, or more than 96 hours following a cesarean section if there are *medically necessary* reasons associated with maternity care will require notification to the health plan.

Newborns' and Mothers' Health Protection Act of 1996

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

Newborn Charges

Medically necessary services, including *hospital* services, are provided for a newborn child of the *member* immediately after birth. In addition, *medical services* for the newborn child shall be provided for the first 31 calendar days following birth. Starting from the date of birth through the first 31 calendar days the newborn maintains an independent *member cost sharing* responsibility including *deductible, copayments* and *coinsurance* when applicable. For continued coverage of the newborn beyond the first 31 calendar days following birth, *members* are required to complete the enrollment process for the newborn and provide premium payment as of the *effective date* of enrollment of the newborn. For additional information regarding premium due dates, please reference the Enrollment of Newborn, Adopted Child or Child Placed for Adoption provision of this *policy*. Each type of *covered service* incurred by the newborn child will be subject to the *member cost sharing* amount listed in the *Schedule of Benefits*.

Newborn coverage and *cost sharing* does not include a person who is a *member's* natural child for whom legal rights have been given up through adoption, or a grandchild of the *member* for whom the *member* does not have court ordered permanent guardianship or custody.

Medically necessary coverage and *cost sharing* for a newborn may be extended beyond the first 31 calendar days without enrolling in the plan as appropriate including:

1. The mother is discharged from the *hospital* and the newborn child remains hospitalized; or
2. The newborn child is readmitted.

The information below details newborn statuses and coverage. Please contact Member Services at the number on the back of your *member* identification card for assistance with understanding your specific situation and applicable coverage.

For newborns discharged within the initial 31 calendar days of coverage, the newborn will be covered by us and has *member cost sharing* that applies to total annual family unit *cost sharing*.

For newborns discharged after the initial 31 calendar days of coverage and not readmitted, the newborn will continue to be covered by us through the date of discharge. Newborns continue to have *member cost sharing* that applies to total annual family unit *cost sharing*.

For newborns discharged and readmitted during the first 31 calendar days from the date of birth, the newborn will continue to have coverage by us through the date of discharge (coverage will be extended beyond the initial 31 calendar days through the date of discharge in this scenario). Newborns continue to have *member cost sharing* that applies to total annual family unit *cost sharing*.

For newborns discharged during the first 31 calendar days and readmitted after the initial 31 calendar days of coverage, the newborn would not continue to be automatically covered by us. To continue coverage after the first 31 calendar days, the newborn must have an enrollment application submitted within 60 calendar days of the date of birth. Failure to enroll a newborn within 60 calendar days following the date of birth will terminate coverage at the end of the initial 31 calendar day period. The continued coverage of the newborn after the initial 31 calendar day period is subject to our receipt of premium payment for such newborn.

Medical and Surgical Expense Benefits

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

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

b. Bone density studies

c. Clinical laboratory tests

d. Gastrointestinal laboratory procedures

e. Pulmonary function tests

f. Genetic testing

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

3. For *medical services* in an office or facility that is provided by a licensed medical practitioner or *specialist physician*, including consultations and surgery-related services.
4. For elective sterilization procedures (e.g., vasectomies). **Note:** No *cost-share* applies, except for HSA-compatible plans.
5. For chemotherapy (including oral chemotherapy), inhalation therapy, infusion therapy, and radiation therapy or treatment in a *hospital* or office setting.
6. For *durable medical equipment*, *prosthetic devices*, *orthotic devices* or other necessary medical supplies following a medical or surgical procedure such as crutches, orthopedic splints, braces or casts. Please see the Durable Medical Equipment provision of this *policy*.
7. For hemodialysis and the charges by a *hospital* or facility for the processing and administration of genetic testing, blood or blood components, including cost of blood, blood plasma and blood plasma expanders, which is not replaced by or for you.
8. For the cost and administration of anesthesia, oxygen, drugs, medications and biologicals.
9. For *medically necessary* reconstructive or *cosmetic surgery* including, but not limited to:

   a. Reconstructive breast surgery charges as a result of a partial or total mastectomy. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and *prosthetic devices* necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedema.

   b. Reconstructive surgery for craniofacial abnormalities.

10. For *medically necessary* dental surgery due to:

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

    b. Cleft lip and cleft palate for an eligible *member*. *Covered services* include medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the treating *physician* or surgeon and such *physician* or surgeon certifies that such services are *medically necessary* and consequent to treatment of the cleft lip or cleft palate.

c. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* charges for dental care, rendered by a dentist, provided to the following *members*:

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

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

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

11. For infertility counseling and planning services when provided by a *network provider* and testing to diagnose infertility to the extent such services and supplies are legal under *applicable law*.

12. For abortions performed to save the life or the health of the *member* or otherwise performed in accordance with *applicable law*.

13. For the treatment of breast cancer by dose-intensive chemotherapy bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy bone marrow transplants or stem cell transplants.

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 this *policy*. See the 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-rays, Magnetic Resonance Imaging (MRI), Computed Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT), and other diagnostic services. See Radiology, Imaging and Other Diagnostic Testing provision of this *policy*.

17. For *medically necessary telehealth services*. *Telehealth services* not provided through *Virtual 24/7 Care* would be subject to the same *cost sharing* as the same health care services when delivered to a *member* in person.
18. For surgery or services related to cochlear implants and bone-anchored hearing aids.
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 the Habilitative Services provision and Rehabilitation Services provision of this *policy*.
21. 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.
22. For *medically necessary* footcare treatment that may require surgery; *prior authorization* may be required.
23. For *medically necessary* nutritional counseling; *prior authorization* may be required.
24. For dermatology services which are limited to *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 procedures.
27. For *medically necessary* chiropractic care or manipulative therapy treatment on an *outpatient* basis only.
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 examinations and pulse oximetry.
29. For *medically necessary* allergy testing and treatment including allergy injections and serum.
30. For *medically necessary* services or treatment for:
    a. A medically verifiable disorder of sexual development; or
    b. *Behavioral health* treatment for gender dysphoria (e.g., psychotherapy).

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

1. Reporting normal laboratory or other test results
2. Office appointment requests

3. Billing, insurance coverage or payment questions
4. Requests for *referrals* to doctors outside the online care panel
5. Benefit precertification
6. *Physician* to *physician* consultation

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

Medical Foods

We cover medical foods and formulas for:

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

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

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

Medical foods coverage must:

1. Be part of the newborn screening program
2. Involve amino acid-based formula carbohydrate or fat metabolism
3. Have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues

Medical foods coverage for Eosinophilic Gastrointestinal Disorder (EGD) must have a diagnosis of EGD.

Residential Enteral Tube Feeding

Medically necessary enteral nutrition is a *covered service* when all of the following apply:

1. Prescribed by a *network physician*
2. For use in the home through enteral feeding tubes

3. Feedings exceed 750 kilocalories a day in order to maintain weight and strength commensurate with the *member's* overall health status

If the requirements above for enteral nutrition are met, supplies, including but not limited to bags, tubing, syringes, irrigation solution, dressings, and tape are also a *covered service*.

Note: Residential enteral tube feeding is covered under the Medical and Surgical Supplies Expense Benefit. Refer to the Medical and Surgical Supplies Expense Benefits for a description of *covered services* and limitations that apply.

Low-Protein Food Products for Treating Inherited Metabolic Disease

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

Benefits for low-protein food products include, but are not limited to, treating the following diseases:

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

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

Medical Dental Services

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

1. *Medically necessary* oral *surgery*, including, but not limited to, the following:
   a. Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.

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

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

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

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

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

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

h. Reconstructive *surgery* to correct significant deformities caused by congenital or developmental abnormalities, *illness*, *injury* or an earlier treatment 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 provided due to a hazardous medical condition, regardless of whether the services are provided in a participating *hospital*, surgical center or office. *Prior authorization* may be required.

3. Dental service expenses when a *member* suffers an *injury* that results in damage to the natural teeth. *Injury* 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. Low vision services and hardware for adults.
4. Eye examinations required by an employer or as a condition of employment.
5. Radial keratotomy, LASIK, and other refractive eye surgery.

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

Mental Health and Substance Use Disorder - Inpatient and Outpatient Services

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

Covered services will be provided on an *inpatient* and *outpatient* basis for the treatment of *mental health disorder* and *substance use disorder* diagnoses. If you need mental health and/or *substance use disorder* treatment, you may choose any *network provider* in order to initiate treatment. You can search for *network behavioral health* providers by accessing our “Find a Doctor" page at AmbetterHealth.com/en/AZ or by calling Member Services. *Deductible amounts*, *copayment* or *coinsurance amounts* and treatment limits for covered *behavioral health* benefits will be provided on the same terms and conditions as medical and surgical benefits.

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

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

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

Inpatient Services

Covered services include:

1. *Inpatient* detoxification treatment
2. Crisis stabilization
3. *Inpatient rehabilitation*
4. *Residential treatment facility* for mental health and *substance use disorders*

5. *Inpatient* psychiatric hospitalization
6. Electroconvulsive therapy (ECT)

Outpatient Services

Covered services include, but are not limited to:

1. Individual, family, and group therapy for mental health and *substance use disorders*
2. Medication assisted treatment – combines *behavioral health* therapy and medications to treat *substance use disorders*
3. *Outpatient* detoxification programs
4. Evaluation and assessment for *mental health disorders* and *substance use disorders*
5. Medication management services
6. Psychological and neuropsychological testing and assessment
7. *Applied behavior analysis (ABA)* therapy
8. *Telehealth* (individual/family therapy; medication monitoring; assessment and evaluation)
9. Partial Hospitalization Program (PHP)
10. Intensive *Outpatient* Program (IOP)
11. Mental health day treatment
12. Electroconvulsive therapy (ECT)
13. *Transcranial magnetic stimulation (TMS)*

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

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

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

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

Other *outpatient services* include benefits such as psychological testing, neuropsychological testing, electroconvulsive therapy, transcranial magnetic stimulation, applied behavior analysis, medication assisted treatment, intensive outpatient programs, partial hospitalization/day treatment (eight hours), partial hospitalization/half day treatment (four hours), laboratory

procedures and habilitation/rehabilitation services (e.g., physical therapy, speech therapy, occupational therapy).

Ambetter from Arizona Complete Health has a *policy* to address any *network* exception needs. Qualified instances in which Ambetter from Arizona Complete Health will make a *network* exception include:

1. There is no provider in our *network* that is accessible or available that can provide you *covered services* in a timely manner; or
2. We review your case and determine that it is in the best interest of your care for you to see a provider outside of our *network*.

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

Nutritional Counseling Services

Nutritional evaluation and counseling from a *network provider* are covered when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition. For *medically necessary* nutritional counseling, *prior authorization* may be required.

Services for the purpose of diet control and weight reduction are not covered, unless required by a specific condition of disease etiology. Services not covered include, but not limited to:

1. Intra oral wiring
2. Gastric balloons
3. Dietary formulae
4. Hypnosis
5. Cosmetics
6. Health and beauty aids

Office Visits

Covered services include:

1. Office visits to *physicians*, including *specialists*
2. Treatment for an *injury* or *illness*
3. Allergy testing, antigen administration, desensitization treatment, allergy treatment and allergen administration in accordance with accepted medical practice, or as otherwise determined to be *medically necessary*

Note: Additional services (including but not limited to x-rays and/or lab testing services) that are performed within an office visit setting may be subject to additional *member cost sharing* in accordance with the *Schedule of Benefits*. *Eligible expenses* for preventive care services do not require *member cost sharing*.

Additionally, some providers (e.g., *PCPs*, *specialists*) may operate out of a *hospital* or facility. **Note:** Applicable *copayments* or *coinsurance* for an office visit may not cover any charges that the *hospital* or facility bills, and you may be responsible for these charges.

Oral and Maxillofacial Surgery

Covered under this benefit:

1. The reduction or manipulation of an acute fracture of facial bones including the jawbone and supporting tissues due to an accidental *injury*
2. Oral surgery for the excisions of lesions, cysts or tumors
3. Reconstruction or repair of the palate or cleft lip

Not Covered:

1. Any treatment for arthroplastic surgery
2. Any services related to malocclusion or malposition of the teeth or jaw
3. Oral implants and transplants

Outpatient Prescription Drug Benefit

This benefit applies only to *prescription drugs* that are prescribed on an *outpatient* basis.

Preventive pharmacy medications require a prescription and are limited to *prescription drugs* and over-the-counter medications that are determined to be preventive as recommended by the United States Preventive Services Task Force (USPSTF) A and B recommendations, as well as FDA-approved over-the-counter contraceptives for women when prescribed by a provider. A listing of these medications may be identified at the following USPSTF website: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

Specific Requirements for Coverage

The following provisions apply to this *prescription drug* benefit:

1. Prescriptions must be included on Ambetter from Arizona Complete Health's *formulary*. For select drugs, your doctor must request *authorization*. Requests for these drugs are evaluated to determine if the established *authorization* criteria are met. A medication must be used in accordance with pharmacy coverage guidelines.
2. All *prescription drugs* must be obtained from a *network* pharmacy.
3. Coverage is provided for *generic*, brand, non-preferred brand and specialty drugs included on the Ambetter from Arizona Complete Health formulary.

4. Preferred retail and specialty pharmacies will dispense prescriptions for up to a 30-day supply.
5. Mail order prescriptions will be dispensed for up to a 90-day supply.
6. Some medications may be dispensed in quantities less than those stated above due to prepackaging by the pharmaceutical manufacturer.
7. Insulin, diabetic supplies and inhalers may have quantity per *copayment* and/or *coinsurance* payment limitations other than 30 calendar days.
8. You will be financially liable for the cost of medications obtained after you are no longer eligible for coverage under this *policy*.
9. Non-formulary (NF) drugs require *formulary* exception for coverage.
10. *Prescription drugs* that are routine patient care provided to *members* participating in clinical trials are covered as required by state and federal law.
11. Medications for weight loss that are listed on the *formulary* may be covered with *prior authorization*.
12. Medications for sexual dysfunction that are listed on the *formulary* may have quantity per *copayment* limitations prescribed in the *formulary*.

If a drug is not on the drug *formulary* and is not specifically excluded from coverage, your doctor can ask for an exception. To request an exception, your doctor can submit a *prior authorization* request along with a statement supporting the request. Requests for *prior authorization* may be submitted by telephone, mail, or facsimile (fax). If we approve an exception for a drug that is not on the *formulary*, the non-preferred brand tier (Tier 3) *copayment* applies. For a standard exception request, we will make a coverage determination no later than 72 hours following receipt of the request. If you are suffering from a condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug that is not on the *formulary*, then you, your designee or your doctor can request an expedited review. Expedited requests for *prior authorization* will be processed within 24 hours after our receipt of the request and any additional information requested by us that is reasonably necessary to make a determination.

Note: This provision does not apply to contraceptive and/or preventive pharmacy medications. Further information regarding contraceptive and/or preventive pharmacy medications may be identified under the Contraceptives and Preventive Pharmacy provision below.

Formulary

Formulary or *prescription drug* list is a listing of covered medications. The *formulary* consists of the following tiers:

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

2. **Tier 1A** –Lowest *copayment* for select drugs that offers the greatest value compared to other drugs used to treat similar conditions. Select over-the-counter (OTC) drugs are covered under this tier.
3. **Tier 1B** – Low *copayment* for those drugs that offer great value compared to other drugs used to treat similar conditions. Select over-the-counter (OTC) drugs are covered under this tier.
4. **Tier 2** –Medium *copayment* covers *brand name drugs* that are generally more affordable or are preferred compared to other drugs to treat the same conditions.
5. **Tier 3** – Non-preferred drugs. High *copayment* covers higher cost brand name and non-preferred *generic drugs*. This tier also covers select non-specialty drugs that are not on the formulary, but approval has been granted for coverage. Please see Prescription Drug Exception Process.
6. **Tier 4** – Highest *copayment* is for specialty drugs used to treat complex, chronic conditions that may require special handling, storage or clinical management. Select *prescription drugs* covered under the specialty tier require fulfillment at a pharmacy that participates in Ambetter's "specialty" or "hemophilia" *networks*.
7. **Tier 6** – Coverage for this tier is for oncology or anti-cancer drugs. *Cost share* is set to be equivalent to your medical benefit *cost share*.

In addition to tiers, the *formulary* also indicates other restrictions that may apply to individual drugs. Summary and explanation of those restrictions can be found in our printed *formulary* and includes, but is not limited to, *prior authorization*, step therapy, quantity limit, age limit, etc. Our Pharmacy and Therapeutics (P&T) Committee determines placement of drugs on the *formulary*. The P&T Committee consists of practicing *physicians* and pharmacists and meets at least quarterly.

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 *formulary* or *prescription drug* list or for more information about our pharmacy program, visit AmbetterHealth.com/en/AZ or call Member Services.

The P&T Committee conducts quarterly reviews of drugs on the Ambetter from Arizona Complete Health formulary to determine the appropriateness of tier positioning, the potential for changes based on new drug arrivals or labeling changes, and any pharmaceutical management protocols that may need to be implemented. Additions of medications to the *formulary* and removal of *formulary* restrictions may occur at any time during the plan year. Certain changes to the *formulary* may result in less favorable coverage for a medication ("negative formulary changes"). Negative *formulary* changes include:

1. Tier increase;
2. Formulary removal;
3. Addition of *prior authorization* or step therapy; and
4. Addition of quantity limits.

Members and prescribers affected by a negative *formulary* change will be notified no less than 60 calendar days prior to the effective date of the change, in accordance with *applicable law*.

Formulary changes made by the P&T Committee are based on the strength of scientific evidence evaluated and are considered against accepted standards of practice including, but not limited to:

1. Assessing peer reviewed medical literature, randomized clinical trials, pharmacoeconomic studies, and outcomes research data;
2. Comparing the safety, efficacy, the frequency of side effects and potential drug interactions among alternative drug products;
3. Assessing the likely impact of a drug product on patient compliance when compared to alternative products;
4. Thoroughly evaluating the benefits, risks and potential outcomes a change could present for patients; and
5. Reviewing and monitoring medication utilization trends and comparing data to recognized and established professional practice standards or protocols to make recommendations for changes in *formulary* positioning.

Voting members of the Committee include practicing community-based practitioners and pharmacists representing various clinical specialties that adequately represent the needs of Ambetter from Arizona Complete Health *members*. Outside specialty consultants, independent and free of conflict with respect to Ambetter from Arizona Complete Health plans and pharmaceutical manufacturers, may be recruited, as deemed necessary, to provide input related to their areas of expertise and to provide advice on specialty practice standards.

Mail Order Pharmacy/Prescription Drug Delivery

The mail order, or extended day supply program is a convenient and affordable way to buy your *maintenance prescription drugs*. A *maintenance* drug is one that has been established as an effective, long-term treatment for your condition. These drugs are used to treat conditions like asthma, heart disease, and high blood pressure.

Through our mail order, or extended day supply pharmacy, you can order up to a 90-day supply of your *maintenance* drug. **Note:** Prescriptions for 60-day supplies or less are subject to the standard *member cost sharing* amount. Refer to the *Schedule of Benefits* for the mail order *member cost sharing* amount. Pharmacists dispense the drugs and then ship them through standard mail at no extra cost to you. Contact Member Services for more information on the mail order program.

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 in mail order delivery or for any additional questions, please refer to our website. Once on our website, you will find details on your in-network mail order pharmacies and next steps for enrollment.

Extended Days' Supply

Maintenance medications are generally taken daily for chronic and lifelong conditions. Extended days' supply fills (up to 90 days) of select *maintenance* medications are available exclusively through select pharmacies. For more information, please consult our website.

Network pharmacies: Up to 31-day supply of maintenance medications and non-maintenance medications
Mail order pharmacies: *Maintenance* medications with days' supply of 31-90 calendar days

Cancer Treatment Medications

Patient administered cancer treatment medications, including medications that are orally administered or self-injected, require no higher *copayment*, *deductible* or *coinsurance amount* than cancer treatment medications that are injected or intravenously administered by a health care provider. Cancer treatment medications mean *prescription drugs* and biologics that are used to kill, slow or prevent the growth of cancerous cells.

Off-Label Use for Cancer Drugs

We cover off-label use for cancer drugs if such use is supported by nationally recognized guidelines such as the National Comprehensive Cancer Network (NCCN) guidelines or studies evidencing effectiveness and safety.

Generic Medication

Certain specialty and non-specialty *generic* medication 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 provision, the tier status as indicated by the *formulary* will be applicable.

Medication Balance-On-Hand

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

Split-Fill Dispensing Program

Members are limited to 15-day supplies for the first 90 calendar 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 calendar days, *members* will fill their medications for 30-day supplies.

Self-injectable Drugs

Self-injectable drugs are delivered into a muscle or under the skin with a syringe and needle. Although medical supervision or instruction may be needed in the beginning, the patient or

caregiver can administer *self-injectable drugs* safely and effectively. *Self-injectable drugs* are covered under the *prescription drug* benefits; *prescription drug cost share* applies.

Medication Synchronization

In accordance with state regulations, upon request, a *member* taking two or more chronic *prescription drugs* may ask a *network* pharmacy to synchronize refill dates so that drugs refilled at the same frequency may be refilled concurrently. This will allow the *copayments* to be prorated based on the synchronized days' supply. For questions about this process, please call Member Services at the number listed at the back of your *member* identification card.

Contraceptives and Preventive Pharmacy

Contraceptive drugs and devices are covered and require a prescription from your *network provider*.

Generic class United States Food and Drug Administration approved contraceptive methods for all women with reproductive capacity are covered when dispensed by a *network* pharmacy. FDA-approved over-the-counter contraceptive methods for women are covered when prescribed by a *network provider*. No *deductible*, *copayment* and/ or *coinsurance* shall apply for each prescription or refill of a *generic drug* when dispensed by a *network* pharmacy. If a *generic drug* is not available, no *deductible*, *copayment* and/ or *coinsurance* shall apply for each prescription or refill of a brand name contraceptive drug. *Deductible, copayment* and/ or *coinsurance* will apply to brand name drugs that have *generic* equivalents, unless the prescriber indicates the brand name drug is *medically necessary*.

Smoking Cessation Medications

Smoking cessation medications, including over-the- counter medications that have been included in the *formulary* by our Pharmacy and Therapeutics Committee, are a c*overed service*.

For information regarding the smoking cessation program available from Ambetter from Arizona Complete Health, contact Member Services.

Prescription Medications

Outpatient prescription medications except as specifically described in the benefit provision titled, Diabetic Equipment, Supplies and Devices, or as otherwise listed as a covered service herein or in the *Schedule of Benefits*.

Non-covered services include:

1. Drugs obtained from a non-network pharmacy;
2. Take home *prescription drugs* and medications from a *hospital* or other *inpatient* or *outpatient* facility;
3. Supplies, medications and equipment labeled "Caution - Limited by Federal Law to Investigational Use";

4. Supplies, medications and equipment deemed *experimental*, unproved or *investigational* by us, except for covered preventive medications (as determined to be preventive as recommended by the United States Preventive Services Task Force (USPSTF) A and B recommendations (medications listed https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations);
5. Any non-prescription or over-the-counter drugs, devices and supplies that can be purchased without a prescription or *physician* order is not covered, even if the *physician* writes a prescription or order for such drug, unless it is an FDA-approved over-the-counter contraceptive method for women, when prescribed by a *network provider*. Additionally, any *prescription drug* for which there is a therapeutic interchangeable non-prescription or over-the-counter drug or combination of non-prescription or over-the-counter drugs is not covered, except as prescribed for treatment of diabetes and for smoking cessation;
6. Supplies, medications and equipment for other than FDA-approved indications;
7. Any drug consumed at the place where it is dispensed or that is dispensed or administered by the *physician*;
8. Supplies, medications and equipment that are not *medically necessary*; as determined by us;
9. Medications for infertility;
10. Medications purchased before a *member's effective date* of coverage or after the *member's* termination date of coverage;
11. Medications used for *cosmetic* purposes as determined by us;
12. Weight reduction programs and related supplies and medications to treat obesity, except as covered under preventive care or listed on the *formulary*;
13. Enteral nutrition when adequate nutrition is possible by dietary adjustment, counseling and/or oral supplements;
14. Drugs that require a prescription by their manufacturer, but are otherwise regulated by the FDA as a medical food product and not listed for a covered indication listed in this document;
15. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance unless listed on the *formulary*;
16. Foreign prescription medications, except those associated with an *emergency 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 provision if obtained in the United States; and
17. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventive treatment is related to *member's* vacation for out of country travel. This provision does not prohibit coverage of treatment for aforementioned diseases.

18. For immunization agents otherwise not required by the Affordable Care Act.
19. For a refill dispensed more than 12 months from the date of a *physician's* order.
20. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs, including early refills of a medication when a *member* has sufficient balance on hand.
21. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program.
22. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
23. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
24. For drugs or dosage amounts determined by Ambetter's Pharmacy and Therapeutics Committee to be ineffective, unproven or unsafe for the indication for which they have been prescribed, regardless of whether such drugs or dosage amounts have been approved by any governmental regulatory body for that use.
25. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
26. For any claim submitted by a non-lock-in pharmacy while *member* is in a lock-in status.
27. For any prescription or over-the-counter version of vitamin(s) unless otherwise included on the *formulary*.
28. Medication refills where a *member* has more than 15 days' supply of medication on hand.
29. Compound drugs, unless there is at least one ingredient that is in an FDA-approved drug.

Lock-in Program

To help decrease overutilization, fraud and abuse, certain *members* identified through our pharmacy 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 from Arizona Complete Health pharmacy, together with Medical Management will review *member* profiles and using specific criteria, will recommend *members* for participation in lock-in program. *Members* identified for participation in lock-in program and associated providers will be notified of *member* participation in the program via mail. Such communication will include information on duration of participation pharmacy to which *member* is locked-in, and any *appeals* rights.

Non-Formulary Prescription Drug Exception Process

Standard exception request

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

Expedited exception request

A *member*, a *member's authorized representative* or a *member's* prescribing *physician* may request an expedited review based on exigent circumstances. Exigent circumstances exist when a *member* is suffering from a health condition that may seriously jeopardize the *member's* life, health, or ability to regain maximum function or when 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 72 hours of the request being received (24 hours for exigent circumstances), we will provide the *member*, the *member's authorized representative* or the *member's* prescribing *physician* with our coverage determination in writing. Should the standard exception request be granted, we will provide coverage of the non-formulary drug for the duration of the exigency.

External exception request review

If we deny a request for a standard exception or for an expedited exception, the *member*, the *member's authorized representative* or the *member's* prescribing *physician* may request that the original exception request and subsequent denial of such request be reviewed by an independent review organization. We will make our determination on the external exception request and notify the *member*, the *member's authorized representative* or the *member's* prescribing *physician* in writing 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 request, we will provide coverage of the non-formulary drug for the duration of the prescription. If we grant an external exception review of an expedited exception request, we will provide coverage of the non-formulary drug for the duration of the exigency.

All approvals and denials will be sent to the *member*, the *member's authorized representative* or the *member's* prescribing *physician* in writing and will include the medical/pharmacological reasoning.

If your request is approved, the exception will last through the end of the plan year and upon renewal of the same plan, though a new exception may be required for renewals.

If your request has been denied, you will be provided with information on the *appeals* process.

Pediatric Vision Benefits – Children under the age of 19

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

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

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

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:

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

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

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.

Preventive screening services for breast cancer or additional screening services required to complete the screening continuum are covered without *cost share*. **Note:** If you are enrolled in a high *deductible* health plan (HDHP) that is HSA-eligible, *deductible* and *cost share* will apply unless it is considered a preventive benefit.

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 without *member cost share*. However, when a service is performed for diagnostic purposes and reported/billed accordingly, it will be considered a non-preventive medical benefit and appropriate *cost share* will apply. **Note:** If preventive and diagnostic services are performed during the same visit, applicable *cost share* will be taken for the latter. For HSA-compatible plans, the *deductible* cannot be waived for benefits that exceed the federal ACA preventive care requirements.

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

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

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 at AmbetterHealth.com/en/AZ. 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 Member Services to get the answers to many of your frequently asked questions regarding preventive services. Our website has resources and features that make it easy to get quality care. Our website can be accessed at AmbetterHealth.com/en/AZ.

Preventive care includes, but is not limited to:

1. Preventive health examinations
2. Well baby care for 47 months
3. Immunizations
4. An annual flu shot, when received in the office of the *PCP* at a *network* pharmacy participating in the vaccine *network*, or at an affiliated flu shot clinic sponsored by the *member's PCP*
5. Hearing screening
6. Vision screening
7. Women's preventive services include, but are not limited to:
    a. Gynecological examinations;
    b. Screening for gestational diabetes;
    c. Human papillomavirus (HPV) DNA testing for women 30 years and older;
    d. Sexually transmitted infection counseling;
    e. Human immunodeficiency virus (HIV) screening and counseling;
    f. FDA-approved contraception methods and sterilization procedures, and contraceptive counseling for women with reproductive capacity;
    g. Breastfeeding support, supplies, and counseling. As prescribed by your *physician*, one breast pump and the necessary supplies to operate it (including pump parts and *maintenance*) will be covered for each pregnancy at no cost to the *member*. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it. Breast pumps can be obtained by contacting Member Services;
    h. Interpersonal and domestic violence screening and counseling.

8. Colorectal cancer screening: Screening colonoscopy and sigmoidoscopy procedures, including related anesthesia services (for the purposes of colorectal cancer screening) will be covered under the preventive care services. Diagnostic endoscopic procedures (except screening colonoscopy and sigmoidoscopy), performed in an *outpatient* facility require the *copayment* or *coinsurance* applicable for *outpatient* facility services.
9. Preventive lab and x-ray;
10. Counseling services: counseling for alcohol misuse, smoking cessation, breastfeeding/lactation, depression/psychological, genetic, healthy diet/ nutrition, obesity in adults and children, preventive medication, sexually transmitted infections, and *tobacco* use;
11. Preventive medications (including smoking cessation medications);
12. Preexposure prophylaxis (PrEP) HIV prevention medication for HIV-negative individuals at high risk of HIV acquisition. **Note:** Includes coverage for related medical support services.

Preventive physical examinations and immunizations will be covered when obtained from or through your *PCP* according to the guidelines and policies adopted by us. This *policy* will not provide less than the minimum benefits required by state and federal laws. Additional examinations and immunizations will be covered if determined to be *medically necessary* by your *PCP*, subject to the limitations and exclusions listed herein.

If a service is considered diagnostic or non-preventive care, your *copayment, coinsurance* and *deductible* will apply. It is important to know what type of service you are getting. If a diagnostic or non-preventive service is performed during the same health care visit as a preventive service, you may have *copayment* and *coinsurance* charges.

Prostate Specific Antigen Testing

When deemed medically appropriate, *covered services* include an annual digital rectal examination and prostate specific antigen test performed to determine the level of prostate specific antigen in the blood.

Radiology, Imaging and Other Diagnostic Testing

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

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

Reconstructive Surgical Services

Covered services include:

1. Surgeries for the correction of disease or *injury* which cause anatomical functional impairment. Coverage of surgical procedures will be based upon the reasonable expectation that the condition or disease will be corrected. The determination process will include our clinical and medical criteria.
2. Reconstructive surgery incidental to *medically necessary* treatment of medically diagnosed services required for the repair of an accidental *injury*, congenital defects and birth abnormalities for *eligible children*.
3. Surgical services for breast reconstruction and for post-operative *prostheses* incidental to a *medically necessary* mastectomy. Coverage includes reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, *prostheses* and physical complications for all stages of mastectomy, including lymphedema and external postoperative *prostheses* subject to all of the terms and conditions of the *policy*.

Rehabilitation Services

Short-term *rehabilitation* services and treatments for acute conditions when significant improvements can be expected in a predictable period of time are covered. A "predictable period of time" means the length of time as submitted by the *PCP* or referring *physician* or as determined by the *rehabilitation specialist* and will require *prior authorization* by us.

Rehabilitation services include, but are not limited to:

1. Physical therapy
2. Occupational therapy
3. Cardiac *rehabilitation*
4. Pulmonary *rehabilitation*
5. Speech and language services limited to:
   a. Corrections of speech impairment, cognitive or perceptual deficits related to an accident, *injury*, stroke or surgical procedure.
   b. Therapies for organic swallowing disorders that are related to a medical condition, such as multiple sclerosis and muscular dystrophy.

Please refer to your *Schedule of Benefits* for maximum allowable day limit per *calendar year*.

The following limitations apply to *rehabilitation* services:

1. Routine and/or non-acute speech therapy is not covered.
2. Services and treatment must be for acute impairment of capacity due to accidental *injury* or other medical conditions.

3. Services are provided on either an *outpatient*, *inpatient* or home basis as determined by the *PCP*, referring *physician* or *rehabilitation specialist* and us.
4. Rehabilitative services are limited to the maximum allowable number of days per year, as specified in the *Schedule of Benefits*, for all services and conditions combined regardless of the number of *injuries* or *illnesses* in one *calendar year*.
5. Services provided on the same day, regardless of place of service (*inpatient rehabilitation*, home health, or *outpatient* facility, or any combination thereof), will count as one day towards the maximum allowable number of days per year, as specified in the *Schedule of Benefits*.
6. Rehabilitative services provided during an *inpatient hospital* stay for which *rehabilitation* is not the primary reason for the *hospital* stay, will not apply to the maximum allowable number of days per year, as specified in the *Schedule of Benefits*.

Covered services do not include:

1. Rehabilitative services related to:
   a. Maintaining physical condition;
   b. *Maintenance* therapy for a chronic condition is not a *covered service*.
2. Continued and repetitive rehabilitative treatment without a clearly defined endpoint is considered *maintenance* and is not covered.
3. Functional capacity or work capacity evaluations are not covered.

Routine Physical Examination

One routine physical examination (including psychological examination or drug screening) per *calendar year*, requested by the *member* without medical condition indications is covered. However, filling out forms related to the physical examination is not covered.

A routine examination is one that is not otherwise medically indicated, or *physician* directed and is obtained for the purposes of checking a *member's* general health in the absence of symptoms or other non-preventive purposes. Example exclusions include examinations taken to obtain employment, or examinations administered at the request of a third-party, such as a school, camp, or sports organization.

Second Opinion

This *policy* covers second opinions by a *physician*. A second opinion is an additional evaluation of a *member's* condition by a *physician* to provide their view about the condition and how it should be treated. To request a *referral* to a *specialist* for a second opinion, contact your *PCP*. All second opinions must be provided by a *physician* who has training and expertise in the *illness*, disease or condition associated with the request.

Skilled Nursing Services

Skilled nursing facility services are covered when determined to be *medically necessary*. *Covered services* include:

1. Admission to a *skilled nursing facility* when appropriate and *medically necessary*.
2. Medical care and treatment, including room and board in semi-private accommodations at a *skilled nursing facility* which is a *network provider* for non-custodial care.
3. *Covered services* shall be of a temporary nature and must be supported by a treatment plan.
4. *Covered services* must be approved in advance through your *PCP* and us with expectations of *rehabilitation* and increased ability to function within a reasonable and generally predictable period of time.
5. *Covered services* are limited to the maximum allowable number of days per year, as specified in the *Schedule of Benefits*, for all services and conditions combined regardless of the number of *injuries* or *illnesses* in one *calendar year*.

Covered services do not include:

1. Custodial or domiciliary care
2. Long-term care admissions

Sleep Studies

Sleep studies are *covered services* 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.

Spinal Manipulations

Covered services for spinal manipulations are covered when determined to be *medically necessary*.

Telehealth Services

We will provide health care services through *telehealth* under the following conditions:

1. We would otherwise provide coverage for the service when provided in person by the *health professional*; and
2. The *member* is accessing care through a *network provider* as defined by their health plan.

Medically necessary telehealth services. *Telehealth services* not provided through *Virtual 24/7 Care* would be subject to the same *cost sharing* as the same health care services when delivered to a *member* in-person.

Services not covered include, but are not limited to, services through *telehealth* if such services are not otherwise covered when provided in-person. Additionally, the sole use of an

audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail without an interaction between the *member* and health care provider for the purpose of diagnosis, consultation or treatment is also not covered.

Temporomandibular Joint (TMJ) Services

Covered services include *medically necessary* services and treatment for temporomandibular joint (TMJ) syndrome including diagnosis and treatment of TMJ that is recognized by the medical or dental profession as effective and appropriate treatment, including intra-oral splints that *stabilize* the jaw joint.

Covered services include services that arise from:

1. Accidental *injury*
2. Physical trauma to the mandible or lower jaw
3. Tumor
4. Congenital defects or developmental defects
5. Orthognathic treatment/surgery, dental and orthodontic services and/or appliances that are orthognathic in nature or change the occlusion of the teeth (external or intra-oral) are covered if approved as *medically necessary*

Surgery and Related Services (Often Referred to as “Orthognathic Surgery” or “Maxillary and Mandibular Osteotomy”)

For the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw or associated bone joints, except when such procedures are *medically necessary*.

The *copayment* or *coinsurance* for TMJ services in connection with acute dislocation of the mandible will vary by place of service pursuant to the *inpatient* and *outpatient* services benefits, respectively. Refer to the *Schedule of Benefits* to determine the applicable *copayment* and/or *coinsurance*.

Transplant Services – Organ and Tissue

Covered services for transplant service expenses:

Transplants are a *covered service* when a *member* is accepted as a transplant candidate and *pre-authorized* in accordance with this *policy*. *Prior authorization* must be obtained through the *Center of Excellence*, a *network* facility, or in our approved non-network facility 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 the applicable medical criteria outlined in the clinical policy which can be found at AmbetterHealth.com/en/AZ.

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 us 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 is due to non-payment of premium, then no services related to transplants will be paid as a *covered service*.

Once medical compatibility has determined that a *member* and donor are an appropriate candidate for a *medically necessary* transplant, or live donation, *covered services* will be provided for both the transplant recipient and the donor:

1. Pre-transplant evaluation services including medical consultations, office visits, laboratory, and diagnostic testing.
2. Pre-transplant collection or harvesting of the organ from the donor.
3. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant).
4. Including *outpatient covered services* related to the transplant surgery, pre-transplant laboratory testing and treatment, such as high dose chemotherapy, peripheral stem cell collection, and other immunosuppressive drug therapy, etc. Also included is the cost for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation.
5. Pre-transplant stabilization, meaning an *inpatient* stay for *medically necessary* stabilization 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 *network* facility.
7. Post-transplant follow-up visits and treatments including medical consultations, office visits, laboratory, and diagnostic testing.
8. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.
9. All ancillary costs incurred and medical expenses by the donor; shall be paid under the transplant recipient *policy*, this includes travel, lodging, food, and mileage.

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

These medical expenses are *covered services* 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 and Our Service Benefits:

A *member* may obtain services in connection with a transplant from any *physician*. However, if a transplant is performed in a *Center of Excellence*, a *network* facility, or in our approved non-network facility when there is no *network* adequacy:

1. We will pay for the following services when the *member* is required to travel more than 60 miles from their residence to the *Center of Excellence*, a *network* facility, or in our approved non-network facility when there is no *network* adequacy.
2. We will pay for the following services, subject to the maximum identified in the *Schedule of Benefits*:
   a. Transportation, including charges for a rental car used during the period of care at the *Center of Excellence*, for the *member*, any live donor, and the companion(s) to accompany to and from the *Center of Excellence*, a *network* facility, or in our approved non-network facility when there is no *network* adequacy in the United States.
   b. When the *member*, donor and/or companion(s) is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
   c. Maximum reimbursement for mileage is limited to the total miles traveled by the transplant recipient and by the donor and their respective companion(s), to and from their respective homes to the transplant facility, plus miles traveled:
      i. Between the transplant facility and local lodging; and
      ii. Between a transit hub (e.g., airport, train station, bus station) and either the transplant facility or local lodging.
   d. Lodging at or near the *Center of Excellence*, a *network* facility, or in our approved non-network facility when there is no *network* adequacy for any live donor and the companion(s) accompanying the *member* while the *member* is confined in the *Center of Excellence*, a *network* facility, or in our approved non-network facility when there is no *network* adequacy in the United States. We will reimburse *members* for the proof of costs directly related to 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/az/resources/handbooks-forms/.

Non-Covered Services and Exclusions:

In addition to any other exclusions and limitations described in this *policy*, there are no benefits provided or paid under these Transplant Service Expense Benefits:

1. For animal to human transplants.
2. For procurement or transportation of a human organ or tissue, not obtained through the *Center of Excellence*, a *network* facility, or in our approved non-network facility when there is no *network* adequacy.
3. To keep a donor alive for the transplant operation, except when *authorized* through the *Center of Excellence*, a *network* facility, or in our approved non-network facility when there is no *network* adequacy.
4. For a live donor to receive an organ transplant to replace the donated organ.
5. Related to transplants unauthorized though the *Center of Excellence*, a *network* facility, or in our approved non-network facility when there is no *network* adequacy and is not included under this provision as a transplant.
6. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (FDA) regulation, regardless of whether the trial is subject to FDA oversight.
7. The acquisition cost for the organ or bone marrow, when provided at an unauthorized facility or not obtained through the *Center of Excellence*, a *network* facility, or in our approved non-network facility when there is no *network* adequacy.
8. For any transplant services and/or travel related expenses for the *member* and donor, when preformed 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 except for approved organ transplant travel services and fuel/charging station fees (unless pre-approved by Case Management);
    c. Vehicle *maintenance* for motorized and hybrid, and electric car (includes: any repairs/parts, labor, general *maintenance*, towing, roadside assistance, etc.);
    d. Parking (unless pre-approved by Case Management);
    e. Storage rental units;
    f. Temporary housing incurring rent/mortgage payments;
    g. *Loss* of wages due to time off from work required for transplant for recipient, donor, or companion(s);
    h. Utilities, such as gas, water, electric, housekeeping services, lawn *maintenance*, etc.;
    i. Moving violation tickets or parking tickets;

j. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.);

k. Any services related to pet care, boarding, lodging, food, and/or travel expenses;

l. Expenses for persons other than the transplant recipient, donor or their respective companion;

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

n. Any expense not supported by a receipt;

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

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

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

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

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

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

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

v. Salon, barber, and spa services;

w. Insurance premiums;

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

Urgent Care Services

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. 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 1-888-926-5057 (TTY 711). The 24/7 Nurse Advice Line is available 24 hours a day, 7 days a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

We encourage *members* to contact their *PCP* before seeking urgent care services.

Covered services for urgent care:

1. Include treatment for unforeseen medical conditions (initial visit only).

2. Are determined by the plan in accordance with generally accepted medical standards to have been necessary to treat a condition requiring prompt medical attention.
3. Treatment provided by a *network provider*.

Covered services do not include:

1. Continuing, routine or follow-up care in an urgent care facility, unless *authorized* by your *PCP*.
2. Treatment provided by a *non-network provider*.

Services performed at an urgent care facility (including but not limited to x-rays and lab testing) may be subjected to additional *member cost sharing* above the urgent care *cost sharing*.

Routine care provided by an urgent care provider is not covered unless *authorized* by your *PCP*. The *member* will be financially responsible for any urgent care provider expenses for non-urgent care. *Routine care* includes, but is not limited to, conditions such as colds, flu, sore throats, superficial *injuries*, minor infections, follow-up care and preventive care.

WELLNESS PROGRAMS AND OTHER OFFERINGS

In connection with this *policy*, we may offer wellness programs and other services to *members* that serve to remove barriers to accessing health services and improve overall health outcomes. These programs and services are available when your coverage begins and continues as long as your coverage remains active. Participation in these programs and services is optional and available at no additional cost to *members*. The programs and services are available to you as part of this *policy* but are not insurance. We may make changes to the terms and conditions of the programs and services or discontinue them at any time. Program tools and services may vary within your market. To inquire about these programs and other offerings, and to learn about what programs are available in your area, please visit our website at AmbetterHealth.com/en/AZ 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 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 d*eductibles, copayments*, and *coinsurance* on *covered services*, with several repayment options to fit their needs. The Ambetter Perks program is offered to all *members*. We are not involved in administering programs; you will communicate directly with any vendors, if you choose to participate.

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

In addition to the limitations and exclusions described in the section titled, Major Medical Expense Benefits, the following services are not covered or are limited in benefit application unless expressly stated herein:

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

1. For abortions unless performed to save the life or the health of the *member* or otherwise not illegal under *applicable law*.
2. For services or expenses for alternative treatments, except as specifically identified as a *covered service* under the *policy*, including acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, biofeedback (when prescribed for reasons other than pain management), behavioral training, educational, recreational, art, dance, dry needling, sex, sleep or music therapy, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
3. *Applied behavior analysis* (ABA) is covered; however, this coverage does not include:
   a. Sensory integration;
   b. LOVAAS therapy; and
   c. Music therapy.
4. For bariatric surgery, benefits are covered for *medically necessary* and not *experimental* or *investigational* services. These *covered services* must be *authorized* by us in accordance with our evidence-based criteria for this intervention contained in our clinical policy on bariatric surgery which can be found at AmbetterHealth.com/en/AZ. Benefits are not payable for expenses excluded in this policy or for:
   a. Open vertical banded gastroplasty
   b. Laparoscopic vertical banded gastroplasty
   c. Open sleeve gastrectomy
   d. Open adjustable gastric banding
5. For blood products. Collection and/or storage of blood products to include stem cells for any unscheduled medical procedure, or non-covered medical procedures. Salvage and storage of umbilical cord and/or after birth are not covered.
6. Braces
   a. Over-the-counter braces
   b. Prophylactic braces
   c. Braces used primarily for sports activities
7. For breast implants, prostheses

a. Breast implants, including replacement, except when *medically necessary*, and related to a *medically necessary* mastectomy.

b. Removal of breast implants, except when *medically necessary*

8. For any medicinal or recreational use of cannabis or marijuana

9. For *chiropractic care*

a. Any services provided by a non-network chiropractor regardless of whether the services were obtained within or outside of the health plan's service area;

b. Any services, including consultations (except for the initial evaluation visit), that are not *authorized* by the designated chiropractic provider as shown in the *Schedule of Benefits*;

c. Any treatments or services, including x-rays, determined to not be related to neuromusculoskeletal disorders;

d. Services which are not provided in a *network* chiropractor's office;

e. Services or expenses which exceed the *member's* maximum allowable benefit. Services which exceed the *member's* maximum allowable benefit will be the *member's* financial responsibility;

f. Expenses incurred for any services provided before coverage begins or after coverage ends according to the terms of this *policy*;

g. Preventive care, educational programs, non-medical self-care, self-help training, or any related diagnostic testing, except that which occurs during the normal course of covered chiropractic treatment;

h. Prescription medications. Vitamins, nutritional supplements or related products, even if they are prescribed or recommended by a *network* chiropractor;

i. Services provided on an inpatient basis;

j. Rental or purchase of *durable medical equipment*, air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices, appliances or equipment as ordered by *network* chiropractor even if their use or installation is for the purpose of providing therapy or easy access;

k. Expenses resulting from a missed appointment which the *member* failed to cancel;

l. Treatment primarily for purposes of obesity or weight control;

m. Vocational rehabilitation and long-term rehabilitation;

n. Hypnotherapy, acupuncture, behavior training, sleep therapy, massage (if not associated with spinal, muscle, or joint manipulation);

o. Services, lab tests, x-rays and other treatments not documented as clinically necessary as appropriate or classified as *experimental or investigational* and/or as being in the research stage;

p. Services and/or treatments that are not documented as *medically necessary* services;

q. Adjunctive therapy not associated with spinal, muscle or joint manipulation;

r. Manipulation under anesthesia.

10. For non-medically necessary circumcisions after the *newborn period*, including cases of premature birth.

11. For communication and accessibility services. Provider expenses for interpretation, translation, accessibility or special accommodations.

12. Complications of non-covered expenses. Non-life-threatening complications of an ineligible or excluded condition, procedure or service (non-covered expenses), including but not limited to, subsequent *surgery* for reversal, revision or repair related to the procedure or services received without *authorization*.

13. For *cosmetic surgery* or reconstructive surgery, which in the opinion of us, is performed to alter an abnormal or normal structure solely to render it more esthetically pleasing where no significant anatomical functional impairment exists. The following are examples of non-covered services:

    a. Rhinoplasty and associated surgery

    b. Rhytidectomy or rhytidoplasty

    c. Breast augmentation/implantation

    d. Blepharoplasty without visual impairment

    e. Breast reduction, which is not *medically necessary*, as determined by us

    f. Otoplasty

    g. Skin lesions without functional impairment, suspicion of malignancy or located in area of high friction

    h. Keloids

    i. Procedures utilizing an implant which does not alter physiologic function

    j. Treatment or surgery for sagging or extra skin

    k. Liposuction

    l. Non-medically necessary removal or replacement of breast implants, as determined by us

    m. 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

    Cosmetic or reconstructive surgery performed, in our opinion, to correct *injuries* that are the result of accidental *injury* is a *covered service*. In addition, this exclusion does not apply to breast reconstruction incidental to a covered mastectomy for either the breast on which the mastectomy has been performed or for surgery and reconstruction of the other breast to produce a symmetrical appearance. Reconstructive surgery incidental to birth abnormalities of a covered *dependent member* is limited to the *medically necessary* care and treatment of medically diagnosed congenital defect and birth

abnormalities. Surgery will be covered past the *newborn period* if *medically necessary* and medical criteria are met.

14. For counseling services. Unless otherwise specifically stated as a *covered service* herein, the following are not covered: marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
15. For court or police ordered services. Examinations, reports or appearances in connection with legal proceedings, including child custody, parole and/or probation and other court ordered related issues. Services, supplies or accommodations pursuant to a court or police order, whether or not *injury* or *illness* is involved, unless otherwise noted within the *policy* or *medically necessary*.
16. For *custodial care* that includes any service, supply, care or treatment that we determine to be incurred for rest, domiciliary, convalescent or *custodial care*. Examples of non-covered services include:
    a. Any assistance with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medications;
    b. Any care that can be performed safely and effectively by a person who does not require a license or certification or the presence of a supervisory nurse;
    c. Non-covered *custodial care* services no matter who provides, prescribes, recommends or performs those services;
    d. Services of a person who resides in the *member's* home, or a person who qualifies as a family member;
    e. The fact that certain *covered services* are provided while the *member* is receiving *custodial care* does not require us to cover *custodial care*.
17. For bionic and hydraulic devices, except when otherwise specifically described herein.
18. For dietary food or nutritional supplements. Non-covered services include:
    a. non-medical dietary food, non-medical nutritional supplements, non-medical special formulas, and special diets provided on an outpatient, ambulatory or home setting;
    b. non-medical food supplements and non-medical formulas, including non-medical enteral nutrition formula, provided in an outpatient, ambulatory or home setting except as otherwise stated herein or in the *Schedule of Benefits*;
    c. non-medical nutritional supplementation ordered primarily to boost protein-caloric intake or the mainstay of a daily nutritional plan in the absence of other pathology, except as otherwise stated herein or in the *Schedule of Benefits*. This includes those nutritional supplements given between meals to increase daily protein and caloric intake.
19. For disability certifications if not required by us.
20. *For durable medical equipment* that fails to meet the criteria as established by us. Examples of non-covered services include, but are not limited to:

a. Exercise equipment, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses, or waterbeds, escalators or elevators, ramps, automobile modifications, safety bars, saunas, swimming pools, Jacuzzi or whirlpools, and hygienic equipment;
b. Equipment for a patient in an institution that is ordinarily provided by an institution, such as wheelchairs, hospital beds and oxygen tents, unless these items have been *authorized* by us;
c. More than one DME device designed to provide essentially the same function;
d. Deluxe, electric, model upgrades, specialized or custom *durable medical equipment*, prosthetics or orthotics or other non-standard equipment;
e. Repair or replacement of deluxe, electric, specialized or custom *durable medical equipment*, model upgrades, and portable equipment for travel;
f. Transcutaneous Electrical Nerve Stimulation (TENS) units;
g. Scooters and other power operated vehicles;
h. Warning devices, stethoscopes, blood pressure cuffs, or other types of apparatus used for diagnosis or monitoring,
i. Model upgrades and duplicates, except as specifically listed as being covered herein;
j. Repair, replacement or routine maintenance of equipment or parts due to misuse or abuse;
k. Over-the-counter braces and other DME devices, except as specifically listed as being covered herein;
l. Prophylactic braces and other DME devices, except as specifically listed as being covered herein;
m. Braces used primarily for sports activities;
n. ThAIRapy® vests, except when our medical criteria are met;
o. Communication devices (speech generating devices) and/or training to use such devices; and
p. Pulse oximeters.

21. For doula services
22. For use of emergency facilities for non-emergency purposes. *Routine care*, follow-up care or continuing care provided in an emergency facility, unless such services were *authorized* by the *PCP* or us.
23. For exercise programs, yoga, hiking, rock climbing and any other types of sports activity, equipment, clothing, devices gym memberships, weight loss programs and meal preparation programs.
24. For benefits and services provided to an ex-member after termination of the ex-member.

25. For *experimental* or *investigational* medical, surgical or other *experimental* health care procedures, services, supplies, medications, devices, equipment or substances. This exclusion does not apply to coverage for routine patient costs provided to *members* participating in approved clinical trials as required by state and federal law and defined in this *policy*.
26. For professional services, supplies or provider *referrals* received from or rendered by a non-Ambetter from Arizona Complete Health contracted *immediate family* member (*spouse*, domestic partner, child, parent, grandparent or sibling related by blood, marriage or adoption) or prescribed or ordered by a non-Ambetter from Arizona Complete Health contracted *immediate family* member of the *member*; *Member* self-treatment including, but not limited to self-prescribed medications and medical self-ordered services.
27. For services or supplies that are obtained by a *member* or non-member by, through or otherwise due to fraud.
28. For open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, and open adjustable gastric banding.
29. For services or supplies in connection with genetic testing, except those for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of *member's* disease or condition to guide treatment decisions when testing has been approved and/or nationally recognized or included in the Preventive Care Expense Benefits provision, as determined by us. Genetic testing, amniocentesis, ultrasound, or any other procedure required solely for the purpose of determining the sex of a fetus.
30. For services provided by any governmental unit except as required by federal law for treatment of veterans in Veterans Administration or armed forces facilities for non-service-related medical conditions. Care for conditions that federal, state, or local law requires treatment in a public facility.
31. For *habilitative services* when medical documentation does not support the *medical necessity* because of the *member's* inability to progress toward the treatment plan goals or when a *member* has already met the treatment plan goals.
32. For speech therapy for occupational or recreational voice strain that could be needed by professional or amateur voice users, including, but not limited to, public speakers, singers, cheerleaders. Examples of health care services that are not habilitative include, but are not limited to, *respite care*, day care, recreational care, residential treatment, social services, *custodial care*, or education services of any kind, including, but not limited to, vocational training.
33. For testing using a patient's hair except to detect lead or arsenic poisoning; hair growth creams and medications; implants; scalp reductions.
34. For heavy metal screenings and mineral studies. Screening for lead poisoning is covered when directed through the *PCP*.
35. For non-medical services or supplies for maternity deliveries at home, other than those required for medical professional or *medically necessary* treatment.

36. For the purchase or rental of household equipment or fixtures having customary purposes that are not medical. Examples of non-covered services include exercise equipment, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses or waterbeds, escalators or elevators, ramps, automobile modifications, safety bars, saunas, swimming pools, Jacuzzi or whirlpools, hygienic equipment or other household fixtures.
37. For ineligible status. Services or supplies provided before the *effective date* of coverage are not covered.
    a. Services or supplies provided after midnight on the *effective date* of cancellation of coverage are not covered.
    b. A service is considered provided on the day it is performed. A supply is considered provided on the day it is dispensed.
38. For services associated with infertility are limited to diagnostic service rendered for infertility evaluation. The following services and treatments are not covered:
    a. Artificial insemination services
    b. Reversal of voluntary sterilization procedures
    c. In vitro fertilization
    d. Embryo or ovum transfer
    e. Zygote transfers
    f. Gamete transfers
    g. GIFT procedure
    h. Cost of donor sperm or sperm banking
    i. Foams and condoms
    j. Medications used to treat infertility
    k. Services, procedures, devices and medications associated with impotence and/or erectile dysfunction unless otherwise specifically stated herein
39. For expenses for services provided solely to satisfy institutional requirements.
40. For any late fees or collection expenses that a *member* incurs incidental to the payment of services received from providers, except as may be required by state or federal law. Court costs and attorney fees. Costs due to failure of the *member* to disclose insurance information at the time of treatment.
41. For services beyond the scope of a provider's license.
42. For lost wages for any reason. Compensation for time spent seeking services or coverage for services.
43. For expenses, services, and treatments from a massage therapist to touch and manipulate the muscles and other soft tissues of the body.

44. For consumable or disposable medical supplies, except as specifically provided herein. Examples of non-covered services include:
    a. Bandages
    b. Gauze
    c. Alcohol swabs and dressings
    d. Foot coverings
    e. Leotards
    f. Elastic knee and elbow supports not provided in the *PCP's* office, except as required by state or federal law
    g. Medical supplies necessary to operate a non-covered *prosthetic* device or item of DME
45. For mental health, *covered services* do not include:
    a. Pre-marital counseling;
    b. School funded/administered services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
    c. Testing of aptitude, ability, intelligence or interest;
    d. Evaluation for the purpose of maintaining employment;
    e. Assertive Community Treatment (ACT).
46. For the following miscellaneous items: blood and blood products; care or complications resulting from non-covered services; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods provision; health club memberships, unless otherwise covered; home test kits, unless required by *applicable law*; care or services provided to a non-member biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *private duty nursing*; *rehabilitation* services for the enhancement of job, athletic, or recreational performance; routine or elective care outside the *service area*; treatment of spider veins; transportation expenses, unless specifically described in this *policy*.
47. For missed appointments, telephone and other expenses, the following are not covered:
    a. Expenses made to a *member* by a provider for not keeping or the late cancellation of appointments.
    b. Charges by *members* or providers for telephone consultations, except for services provided through telehealth if such services are otherwise covered when provided in person, and clerical services for completion of special reports or forms of any type, including but not limited to disability certifications are not covered.
    c. Charges by *members* or providers for copies of medical records supplied by a health care provider to a *member*.

48. 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.
49. For expenses, services, and treatments from a naturopathic *specialist* for treatment of prevention, self-healing and use of natural therapies.
50. For treatment or services rendered by non-licensed health care providers and treatment or services outside the scope of a license of a licensed health care provider or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed *physician*, except for services related to *behavioral health* treatment for *autism spectrum disorder*.
51. For non-medically necessary services, supplies, treatments or accommodations which are not *medically necessary* except as specifically described herein.
52. For benefits and services from non-network pharmacies (any pharmacy that has not contracted with Ambetter from Arizona Complete Health to provide prescription medications to *members* covered under this *policy*) are not covered.
53. For benefits and services from *non-network providers*, except in the case of a medical emergency or under an approved *network* exception.
54. For services of nutritionists and dietitians, except as incidentally provided in connection with other *covered services*.
55. For treatment or surgery for obesity, weight reduction or weight control, except when provided for morbid obesity or as a preventive care service.
56. For orthotics as described below:
    a. Repair, maintenance and repairs due to misuse and/or abuse.
    b. Over-the-counter items, except as specifically listed as being covered herein.
    c. Prophylactic braces.
    d. Braces used primarily for sports activities.
57. For unauthorized services received outside of the *service area*, except for *emergency services* while traveling within the United States or outside the United States for up to a maximum of 90 consecutive days from the start of travel, even if enrollment occurs during the period of travel, or as defined in this *policy*. Examples of non-covered services include:
    a. Non-emergent services or treatments which could have been provided by a *network* provider within the service area;
    b. Non-emergent services which were furnished after the member's condition would have permitted the member to return to the service area for continued care;
    c. Non-emergent services connected with conditions resulting during travel which had been advised against because of health reasons such as impending surgery and/or delivery. This does not apply to *emergency services* as defined in this policy; and
    d. Treatment in progress by a *network* provider.

58. For over-the-counter items and medications, except as specifically listed as a covered service herein. Exceptions covered herein include covered preventive medications, and medications as indicated under the provisions titled, Diabetic Equipment, Supplies and Devices. For purposes of this *policy*, over-the-counter is defined as any item, supply or medication which can be purchased or obtained from a vendor or without a prescription.
59. For oxygen when services are outside of the *service area* and non-emergent or urgent, or when used for convenience when traveling within or outside of the *service area*.
60. For diagnostic testing to establish paternity of a child.
61. For personal comfort or convenience items, including services such as guest meals and accommodations, telephone expenses, non-qualified travel expenditures, take-home supplies, barber or beauty services, radio, television and private rooms unless the private room is *medically necessary*.
62. For physical health examinations in connection with:
    a. Obtaining or maintaining employment,
    b. Obtaining or maintaining insurance qualification.
63. For psychiatric or psychological examinations, testing and/or other services in connection with:
    a. Obtaining or maintaining employment
    b. Obtaining or maintaining insurance relating to employment or insurance
    c. Obtaining or maintaining any type of license
    d. Medical research
64. For health conditioning programs and other types of physical fitness training. Exercise equipment, clothing, performance enhancing drugs, nutritional supplements and other regimes.
65. For prescription medications, refer to the *outpatient prescription drug* benefit for the restrictions and limitations that apply.
66. For *private duty nursing* for expenses, services, and treatments related to *private duty nursing* in an *inpatient* location. Private rooms except when determined to be *medically necessary* as determined by us. *Private duty nursing* does not include non-skilled care, *custodial care*, or *respite care*.
67. For charges by any public or private school or halfway house, or by their employees.
68. For radial keratotomy, LASIK surgery and other refractive eye surgery.
69. For residential treatment that is not *medically necessary*. Admissions that are not considered medically appropriate and are not covered include admissions for wilderness center training; for *custodial care*; for a situational or environmental change; or as an alternative to placement in a foster home or halfway house.
70. For expenses, services or treatments for *respite care* to provide short-term relief for primary caregivers.

71. For expenses for services to reverse voluntary sterilization.
72. For all shipping, delivery, handling or postage expenses except as incidentally provided without a separate charge, in connection with *covered services* or supplies. Interest or finance charges except as specifically required by law.
73. For skin titration (wrinkle method), cytotoxicity testing (Bryans Test), RAST testing, MAST testing, urine auto-injection, provocative and neutralization testing for allergies.
74. For speech therapy services, *maintenance* and/or non-acute therapies, or therapies where a significant and measurable improvement of condition cannot be expected in a reasonable and generally predictable period of time as determined by us in consultation with the treating provider. Any combination of therapies (including speech and language therapies) that exceed the maximum allowable benefits as described in the *Schedule of Benefits*. Communication devices (speech generating devices). Rehabilitative services relating to developmental delay, provided for the purpose of maintaining physical condition, or *maintenance* therapy for a chronic condition are not covered. However, *rehabilitation* and habilitation therapy for physical impairments in *members* with *autism spectrum disorder* that develops or restores, to the maximum extent practicable, the functioning of an individual, is considered *medically necessary* when criteria for *rehabilitation* and habilitation therapy are met.
75. For substance use services. *Covered services* do not include:
    a. Referral for non-medically necessary services such as vocational programs or employment counseling.
    b. Expenses related to a stay at a sober living facility. Sober living facilities are *custodial care* institutions, which are not a *covered service*.
76. For *surrogacy arrangements*. Health care services, including supplies and medication, to a non-member *surrogate*, and any child born as a result except where the child is the adoptive child of a member possessing an active policy with us and/or the child possesses an active policy with us at the time of birth. This exclusion applies to all health care services, supplies and medication to a non-member *surrogate* including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the surrogate following childbirth);
    d. *Mental health disorder* services related to the *surrogacy arrangement*;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
    g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
    h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement*, including but not limited to labs, imaging, and diagnostics;

i. Any complications of the child or *surrogate* resulting from the pregnancy;

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

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

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

m. For any other medical or healthcare services related to the pregnancy or preparations of becoming a *surrogate* or donor will not constitute as a covered benefit.

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

77. For temporomandibular joint disorder. *Covered services* under the medical portion of your health plan do not include:

a. Dental *prostheses* or any treatment on or to the teeth, gums, or jaws and other services customarily provided by a dentist or dental *specialist*;

b. Treatment of pain or infection due to a dental cause, surgical correction of malocclusion prognathic surgery, orthodontia treatment, including *hospital* and related costs resulting from these services when determined to relate to malocclusion; and

c. Treatment of obstructive sleep apnea.

78. For thermography or thermograms related expenses.

79. For transplants that do not include:

a. Services, supplies and medications provided to a donor of organs and/or tissue, for transplants where the recipient is not a *member* covered under this *policy*.

b. Transplants that are considered *experimental* or *investigational*.

c. If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this *policy* will be provided for both you and the donor. In this case, payments made for the donor will be charged against the *member's* benefits.

This exclusion does not apply to coverage for routine patient costs provided to *members* participating in approved clinical trials as required by state and federal law as defined in this *policy*.

80. For transportation of a *member* to or from any location for treatment or consultation, except for ambulance services associated with a *medically necessary emergency condition* and travel services associated with organ transplant benefits.

81. For travel and room and board, even if prescribed by a *physician* for the purpose of obtaining *covered services*. This does not apply to *qualified travel expenditures*.

82. For expenses or services related to immunizations and vaccinations for occupational purposes.
83. For the use of *urgent care centers* for non-urgent care purposes, *routine care*, follow-up or continuing care provided in an *urgent care center*, services provided by a non-network urgent care facility.
84. For vehicle installations or modifications which may include adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.
85. For vitamin B-12 injections are not covered except for the treatment of pernicious anemia when oral vitamin B cannot be absorbed.
86. For vocational programs and counseling for employment, including counseling during mental or substance use *rehabilitation*.
87. For expenses in connection with a work-related *injury* or *illness* for which coverage is provided under any state or federal Worker's Compensation, employer's liability or occupational disease law.
88. For routine pediatric dental services, except as expressly provided for under the Major Medical Expense Benefits section.
89. For any specified sex-trait modification procedures, in accordance with federal regulations in 45 CFR § 156.115(d), which include any pharmaceutical or surgical intervention that is provided for the purpose of attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex either by intentionally:
    a. Disrupting or suppressing the normal development of natural biological functions, including primary or secondary sex-based traits; or
    b. Altering an individual's physical appearance or body, including amputating, minimizing or destroying primary or secondary sex-based traits such as the sexual and reproductive organs.

TERMINATION

Termination of Coverage

This *policy* may be terminated by us upon occurrence of any of the following:

1. If premium payments for the *member* and enrolled dependents are not received within the grace period defined in this *policy*, coverage may automatically terminate. The date of termination will be the last day of the month for which premium payments have been received and accepted by our Accounts Receivable Department. Refer to the Reinstatement section below for further information on how to re-enroll.
2. If a *member* performs an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact under the terms of this *policy*, coverage for that individual may be terminated. Notice of termination will be provided by us and mailed to the *member's* address of record. Acts of fraud or intentional misrepresentation include:
   a. Knowingly furnishing incorrect or incomplete information to us in order to obtain benefits for the *member*, enrolled dependents, or a non-enrolled individual; or
   b. Allowing another person to use your *member* identification card or allowing a *member* to use another person's *member* identification card.
3. An individual whose coverage is terminated under this provision will be prohibited from enrolling under any plan offered by us in the individual market. If a *member's* coverage is terminated under this provision, their enrolled dependents may apply for coverage under their own individual plan.
4. If we discontinue coverage for this particular health plan in the State of Arizona, coverage under this *policy* will terminate. A 90-day written notice of termination will be provided by us and mailed to the *member's* address of record. The *member* and their enrolled dependents will have the option of purchasing other health insurance offered by Ambetter from Arizona Complete Health in the individual market.
5. If we cease to offer coverage in the individual market in the State of Arizona, coverage under this *policy* will terminate. A 180-day written notice of termination will be provided by us and mailed to the *member's* address of record.
6. If a *dependent member* fails to meet the eligibility requirements, coverage for that *dependent member* will terminate without further notice to *member*. The *effective date* for termination under this *policy* will be the last day of the month in which the qualifying event occurred.
7. 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 we receive a request from you to terminate this contract, or any later date stated in your request will be effective the last day of the requested month.

We are not responsible for the cost of health care services received by a *member* after the date of termination. If a *member* is confined in a *hospital* or other *inpatient* facility on the date

of termination, coverage will cease on that date, except as specifically stated as otherwise herein.

If a *member* elects to terminate coverage hereunder, and accepts coverage under another health plan, we will pay expenses for that *member* until midnight on the date the *member's* coverage is scheduled to terminate.

Cancellation

A *member* desiring to cancel this *policy* shall provide advance written notice to the Federally Facilitated Marketplace, or if an off-exchange *member* by written notice to the entity in which you enrolled. Benefits under this *policy* shall terminate for all *members* on the last day of the month for which cancellation has been requested, or on the last day of the month for which premium payments have been received by us, whichever first occurs. In no event will a request for cancellation be processed retroactive to the date for which premium payment has been received and accepted by our Accounts Receivable Department. Cancellation of *member's* membership will also terminate coverage for a *member's* enrolled dependents.

Refund upon Cancellation

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

Loss of Dependent Member Eligibility

A *dependent member* whose coverage is terminated for *loss* of eligibility may apply for coverage under their own individual plan, provided such *dependent member* meets the *member* eligibility requirements, submits a completed and signed enrollment application to the Federally Facilitated Marketplace, for Marketplace coverage, or to us, for off-exchange coverage, within 60 calendar days of the termination date of coverage hereunder, and submits the required premium payment to us. Coverage shall be in accordance with the rules and regulations that may have in effect at the time such *dependent member* applies for individual coverage. Such rules and regulations may include those relating to coverage, amount of premium payment, and all other terms and conditions governing individual membership. Enrollment applications which are submitted more than 60 calendar days following *dependent member's* termination will be subject to open and *special enrollment periods* and will have an *effective date* in accordance with the rules and regulations in effect at the time of coverage approval.

Rescission of Coverage

We may rescind this *policy* for any fraudulent or intentional omission or intentional misrepresentation of material facts in the written information submitted by you or on your behalf on or with your enrollment application.

A material fact is information which, if known to us, would have caused us to decline to issue coverage. If this *policy* is rescinded, we shall have no liability for the provision of coverage under this *policy*.

By signing the enrollment application, you represented that all responses to the Statement of Health were true, complete and accurate, to the best of your knowledge, and that should we accept your enrollment application, the enrollment application would become part of the *policy* between us and you. By signing the enrollment application, you further agreed to comply with the terms of this *policy*.

If we make a decision to rescind your coverage, such decision will be first sent for review to an independent third-party auditor contracted by us.

If this *policy* is rescinded, we will provide a written notice that will:

1. Explain the basis of the decision and your *health care appeal* rights;
2. Clarify that all *members* covered under your coverage other than the individual whose coverage is rescinded may continue to remain covered; and
3. Explain that your monthly premium will be modified to reflect the number of *members* that remain under this *policy*.

If this *policy* is rescinded:

1. We may revoke your coverage as if it never existed and you will lose health benefits including coverage for treatment already received;
2. We will refund all premium amounts paid by you, less any medical expenses paid by us on behalf of you and may recover from you any amounts paid under the *policy* from the original date of coverage; and
3. We reserve our right to obtain any other legal remedies arising from the rescission that are consistent with Arizona law.

If your coverage is rescinded, you have the right to appeal our decision to rescind such coverage.

Reinstatement

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

CLAIMS

How to File a Claim for Covered Services – Network Providers

Network providers will file claims on your behalf with us for *covered services*. Present your *member* identification card at the time of service. Payment for *covered services* will be made directly to the *network provider*. You will be responsible for *copayment, deductibles*, *coinsurance amounts*, any non-covered or excluded expenses, and amounts over specifically limited benefits. Please refer to the provider directory for a list of *network providers*.

How to File a Claim for Covered Services - Non-network providers

In the case of *emergency services* or as *authorized* by Ambetter from Arizona Complete Health, you may need to get care from *non-network providers*. 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 they do not, send a copy of your paid itemized bill to us, along with a completed claim form which can be obtained from our website. Payment of the billed expense amount for *covered services*, as defined in this *policy*, will be paid to you subject to applicable *copayments, deductibles* and *coinsurance amounts*, unless we are directed otherwise, or as required by *applicable law*. You will be responsible for *copayments, deductibles*, *coinsurance amounts*, any non-covered or excluded expenses, and amounts over specifically limited benefits.

Claims Incurred for Emergency Services While Traveling Outside the United States

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

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

Proof of departure from and arrival to the United Status must be submitted with the claim. These documents must be submitted with the Member Reimbursement Medical Claim Form, along with all requested documents as detailed on the claim form. All forms and *member* resources are available at AmbetterHealth.com/en/AZ.

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.

Claims should be addressed to:

Ambetter from Arizona Complete Health
ATTN: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

Payment of Claims

Time of payment of claims: Payment payable under this *policy* for any claim for which this *policy* provides any periodic payment, will be paid immediately upon receipt of due written proof of allowed services. Subject to due written proof of allowed services, all accrued payments for services for which this *policy* provides periodic payment will be paid, and any balance remaining unpaid upon the termination of liability will be paid upon receipt of written proof of allowed services, subject to terms of the *policy*. Providing all information that is necessary to process a claim has been received, claims will be processed within 30 calendar days of receipt.

Physical Examination and Autopsy

We have the right to have any *member* examined at our expense while a claim is pending payment. We also have the right to have an autopsy performed where it is not prohibited by law. These examinations are made at our expense and as often as we may reasonably require.

Double Coverage

If an individual is both enrolled as a *member* under this *policy*, and entitled to benefits under any other coverage described below, our responsibility for services and supplies provided to the *member* for the treatment of any one *illness* or *injury* shall be reduced by the amount of benefits paid for the treatment of that same *illness* or *injury*, which resulted from the *member's* payment for such services and supplies from any other source.

This provision is applicable to any service and supplies, including room and board, provided to the *member* by any municipality, county, federal or state governmental agency or other political subdivision. This provision shall not apply to:

1. Any medical assistance benefits and services to which a *member* is entitled pursuant to the Arizona medical assistance program; or
2. *Covered services* received by a veteran *member* in a Veterans Administration or armed forces facility as required by federal law.

Right to Receive and Release Information

We may release or receive any information considered to be necessary for us to coordinate benefits with respect to any person claiming benefits under this *policy* and without any additional consent or notice to the *member* or any other person or organization. We shall not, however, be required to determine the existence of any other group payor or insurer or the benefits payable under such payor or insurer when computing *covered services* due a *member* under this *policy*.

Recovery of Overpayment

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:

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.

Facility of Payment

Payment(s) made under another plan, which included amounts that should have been paid by us, shall be reimbursed to that entity and treated as though it was a benefit paid under this plan. We will not be required to pay that amount again. The term payment(s) made shall include providing benefits in the form of services, in which case payment(s) made will be interpreted as the reasonable cash value of the benefits provided in the form of services.

Medicare

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

The benefits under this *policy* are not intended to duplicate any benefits to which *members* are entitled under Medicare. All sums payable under such programs for services provided shall be payable to and retained by us. Each *member* shall complete and submit to us such consents, releases, assignments and other documents as we may request in order to obtain or assure reimbursement under Medicare or any other government program for which *members* are eligible. In cases where Medicare or another government program (excluding Arizona AHCCCS) has primary responsibility, Medicare benefits will be taken into account for any *member* who is enrolled for Medicare. This will be done before the benefits under this health plan are calculated.

In cases where Medicare or another government program (excluding Arizona AHCCCS) has primary responsibility, Medicare benefits will be taken into account for any *member* who is enrolled for Medicare. This will be done before the benefits under this health plan are calculated.

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

Any rules for coordination of benefits will be applied after benefits have been calculated under the rules in this provision. The allowed amount, which is either the contracted amount or the Medicare *allowed amount* (whichever is less) will be reduced by any Medicare benefits available for those expenses.

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

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

Health Care Liens

When there is a source of payment for a *covered service* in addition to the coverage provided by us, such as, for example, a liability insurer, government payer or uninsured and/or underinsured motorist coverage *network providers* may collect from that other source any difference between the negotiated amount of payment agreed upon between us and the *network provider* for a covered service and the *network provider*'s customary charge, by following the procedures set forth in Arizona law (A.R.S. Sec. 33-931).

Worker's Compensation

The benefits which a *member* is entitled to receive under this *policy* are not designed to duplicate any benefits to which the *member* is entitled under workers' compensation law. We are entitled to reimbursement for any services that have been reimbursed under a workers' compensation claim.

1. *Member* is required to file for workers' compensation when an employment related accident, *illness* or *injury* occurs.
2. If the *member's* workers' compensation carrier denies a claim, the *member* may submit the claim to us with a copy of the denial for consideration under this *policy*. All plan provisions of this *policy* will apply in the consideration process for payment under this plan.
3. Workers' compensation claims that are not a benefit under this *policy* are not payable by us.
4. Any benefits payable are subject to all provisions of this *policy*, including, but not limited to the *authorization* requirements.

Non-Assignment

The coverage, rights, privileges and benefits provided under this *policy* are not assignable by you or anyone acting on your behalf. Any assignment or purported assignment of coverage,

rights, privileges and benefits provided for under this *policy* that you may provide or execute in favor of any *hospital*, provider, or any other person or entity shall be null and void and shall not impose any obligation on us.

No Third-Party Beneficiaries

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

GRIEVANCE, HEALTH CARE APPEALS AND EXTERNAL REVIEW PROCEDURES

Your Satisfaction Is Our Concern

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.

You may, on occasion, be dissatisfied with quality of care, service issues, or the denial of a claim or request for service. Below is a brief description of each process. Please see your separate information package titled Arizona Health Care Insurer Appeals Process Information Packet for a full description of the Appeal process including the different levels of appeal available to you.

Anytime you have a concern about the quality of care you receive, the level of our service or any other aspect of your health plan experience– we want to know. Call us toll free at 1-888-926-5057 (TTY: 711). Many times, a single phone call to Member Services staff can address your concerns.

In addition to calling Member Services, there are other avenues for you to use if you do not agree with a decision made by us or by one of the health care professionals who work with us. Like you, we want to be sure the appropriate decisions are made regarding your medical care and that you receive the benefits your health plan covers.

Should You File a Grievance or a Health Care Appeal?

Grievance

You initiate a *grievance* when you are not satisfied with the quality of care or service you are receiving. A *grievance* is the step you take to tell us that we are not meeting your expectations. A *grievance* tells us that you are not pleased with the quality of medical care or the service that you received. A *grievance* brings your concern to our attention.

We want you to let us know how we can improve any aspect of your medical care, preventive health benefits, customer service or your understanding of your health plan. Call, write or fax your *grievance* to us within 180 calendar days. We will acknowledge receiving your *grievance* within five business days. You will receive a decision within 60 calendar days. Occasionally, we may need additional time to review your issue. We will send written information explaining our need for additional time to review your issue. We will not extend our review time beyond 14 additional calendar days. Every *grievance* about the quality of medical care is taken seriously. That’s why we have a Quality Improvement Department for investigation and follow-up with the doctor or facility that provided the care. Quality of Care related *grievance* reviews are part of a confidential process so we may not be able to give detailed outcome information; however, we will communicate to you when the case has been open and resolved.

To file a *grievance*, we can be contacted Monday through Friday from 8 a.m. to 8 p.m. at 1-888-926-5057 (TTY: 711).

Appeals

Arizona law requires us to provide you with a way to appeal any *adverse benefit determinations*, including but not limited to, denied claims or denied services. A “denied claim” is when you have already received care, submitted a claim, and we have denied the claim.

A “denied service” is when Arizona Complete Health refuses to *authorize* a service that is covered, such as a *referral* to a *specialist*, or if we deny a *pre-authorization* request for a treatment or procedure that you or your doctor believe is *medically necessary* and covered by your *policy*.

When we deny a claim or service, we will advise you of your right to appeal the denial. The appeals process **does not** occur unless you, someone you designate (including an attorney), or your treating provider has specifically requested that we reconsider our decision. When we issue a decision in response to you, or your treating provider’s original request for service, or payment, we include information on the next level of *appeal* available to you, including filing instructions and contact information. The appeals process consists of the following levels of review:

For Urgent Services Not Yet Provided (Pre-Service):

Expedited Medical Review: For urgently needed services where you and your treating provider decide that the standard initial appeal process (about 30 calendar days) is likely to cause a significant negative change in your medical condition.

We have 72 hours after receiving the information from the treating provider to decide whether we should change our decision and *authorize* the requested service.

Expedited Appeal: If we deny your expedited medical review, you and your treating provider may request an expedited appeal.

We shall provide notice of the expedited appeal decision within 72 hours.

Note: If the expedited appeal request does not include the treating provider certification, we review the appeal under the non-urgent initial appeal process.

Expedited External, Independent Review: You may request an expedited external independent appeal only after you have appealed through the expedited medical review and expedited appeal levels of review, or simultaneously at any internal level of review. You have four (4) months after you receive our expedited appeal decision to send us your written request for an expedited external independent review. We will acknowledge receiving your request within one business day.

For Non-Urgent Services:

Initial Appeal: You, or your treating provider, have two years from the initial denial to request an initial appeal of your denied request for a service or to dispute an unpaid (denied) claim payment.

We will acknowledge receiving your initial appeal within five business days. For pre-service appeals, we have 30 calendar days from the receipt date to decide if we should change our decision and *authorize* the requested services.

For post-service appeals, we have 60 calendar days from the receipt date to decide if we should change our decision and pay the denied claim.

External, Independent Review: You may request a non-urgent external independent review only after you have completed an initial appeal. You have four months after you receive our initial appeal decision to send us your written request for external independent review. We will forward your request and all of the documentation previously reviewed during your initial appeal to the Arizona Department of Insurance and Financial Institutions, who will decide whether Ambetter from Arizona Complete Health should cover the requested service, or they will send the appeal to an independent review organization (IRO) to determine if the service is *medically necessary*.

Neither you nor your treating provider is responsible for the cost of any external independent review.

If you, your treating provider, or we disagree with the Arizona Department of Insurance and Financial Institutions director's final decision on a contract coverage issue, a request for a hearing with the Office of Administrative Hearings ("OAH") can be filed within 30 calendar days of receiving the director's decision. OAH schedules and completes a hearing for appeals from external independent review decisions.

Please refer to your Arizona Health Care Insurer Appeals Process Information Packet for detailed information on all levels of the appeal process. The Arizona Health Care Insurer Appeals Process Information Packet was delivered with your *policy*. If you need another packet mailed to you, please contact Member Services, Monday through Friday from 8 a.m. to 8 p.m.

To Get Started

Phone

Just call Member Services, Monday through Friday from 8 a.m. to 8 p.m. at 1-888-926-5057 (TTY: 711).

Mail

You may file standard *health care appeals* in writing to:

Ambetter from Arizona Complete Health
ATTN: Ambetter Appeals and Grievance Dept.
P.O. Box 10341
Van Nuys, CA 91410-0341

Fax

You may also fax a written *health care appeal* to the Ambetter Appeals and Grievance Department at 1-877-615-7734.

The Role of The Director of the Arizona Department of Insurance and Financial Institutions

The Director of the Arizona Department of Insurance and Financial Institutions oversees this appeals process. The director maintains a copy of each health plan's *utilization review policy*; receive, process, and act on requests from health plans for external independent review; review and enforce or overturn the decisions of the health plans; and file appropriate reports with the Arizona legislature. In instances where the director is sometimes unable to determine issues of coverage, they forward the case to the independent review organization (IRO) to complete a review within 21 calendar days of receipt. The director has five business days after receiving the IRO's decision to send the decision to you, your treating provider and us. When necessary, the director must transmit appeal records to the Superior Court or the Office of Administrative Hearings and issue final administrative decisions.

Other Grievance and Appeal Information

General Eligibility Standard Appeals and Premium Disputes

We do not review any disputes regarding eligibility and/or premiums for policies purchased through the Marketplace. However, under federal law, you and your health care decision-maker have the right to file a dispute within a reasonable timeframe regarding your eligibility, which may include a determination of your eligibility for an enrollment period, including for *special enrollment periods*. You may also file any disputes regarding your premiums or premium assistance directly to the Marketplace.

You may contact the Marketplace by telephone at 1-800-318-2596 or 1-855-889-4325 (TTY: 711), which is available 24 hours a day, 7 days a week or online at https://www.healthcare.gov/marketplace-appeals/appeal-forms. You may send your written appeal by fax to 1-877-369-0130 or by mail to:

Health Insurance Marketplace
ATTN: Appeals
465 Industrial Boulevard
London, KY 40750-0061

After the Marketplace reviews your dispute and you do not agree with their decision, you have an additional right to appeal that decision through the U.S. Department of Health and Human Services (HHS). You must file your dispute to HHS within 30 calendar days of the Marketplace's notice to you of their dispute decision. You may contact the HHS at their toll-free call center: 1-877-696-6775.

You may find additional information regarding your appeal rights through the Marketplace's website at: https://www.healthcare.gov/contact-us and/or through the HHS' website at https://www.hhs.gov/healthcare/index.html.

Getting Your Medical Records

Under Arizona law, you and your health care decision-maker are entitled to a copy of your medical records from any health care professional that has treated you. Make your request in

writing and be sure to include the address where you want your records sent. In some cases, your records will be sent only to the medical professional that you have designated.

Confidential Medical Information

Your medical records are confidential. They are used only as needed to make decisions about your care – or any appeals you may file. During an appeal, Arizona Complete Health may release some portions of your medical records to the people who are reviewing your case.

Mailing Documents

We want to be sure our response reaches you. Please confirm that we have your current mailing address in our records because that is where documents will be sent. We consider information mailed to you to be received on the fifth business day.

Questions

If you have questions or need assistance, please call Member Services at 1-888-926-5057 (TTY: 711).

Medical Malpractice Disputes

Any disputes alleging the medical malpractice, negligence and/or wrongful act of a health care provider, or *injury* or property damage caused as a result of an accident at the premises of a health care provider, shall not include us and shall include only the provider subject to the allegation. Ambetter from Arizona Complete Health, and plan providers are independent contractors in relation to one another.

Access to Medical Records

We are entitled to receive from any provider who renders *covered services* to a *member* all information reasonably related to such services. Subject to applicable confidentiality requirements, *members* authorize any provider rendering *covered services* to disclose all facts pertaining to the *member's* care and treatment by the provider and to permit copying of reports and records by us. *Member* agrees to execute a release and/or authorization for us to obtain medical records if requested by us during the term of the *member's* coverage. We reserve the right to reject or suspend a claim based on lack of medical information or records.

Confidentiality

We shall preserve the confidentiality of the *members*' health and medical records consistent with the requirements of applicable Arizona and federal law.

GENERAL PROVISIONS

Entire Policy

This *policy*, the *Schedule of Benefits*, and the individual enrollment application, including any amendments or riders attached, constitute the entire *policy* between Ambetter from Arizona Complete Health and the *member*, and supersede all prior and existing arrangements, understandings, negotiations, and discussions, whether written or oral, of the parties. There are no warranties, representations, or other agreements between us and the *member* in connection with the subject matter of this *policy*, except as specifically set forth herein. No supplement, modification or waiver of this *policy*, other than as specifically provided for herein, shall be valid unless executed in writing by the President of Arizona Complete Health or an authorized executive officer of Arizona Complete Health. No agent has the authority to change this *policy* or to waive any of its provisions.

Non-Waiver

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

Time Limit on Certain Defenses

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

Amendment or Modification

This *policy* shall be subject to amendment, modification or termination in accordance with the provisions hereof. We will provide the *member* 60-day prior written notification of any amendment or material modification to this *policy*, including the *Schedule of Benefits*. Notice will be sent to the *member's* address of record. Receipt of premium payment will constitute the *member's* acceptance of the amendment or modification. Consent of enrolled *dependent members* is not required. The *member's* failure to make premium payment will automatically terminate coverage under this *policy*. The date of termination will be the last day for which premium payment has been received and accepted by our Accounts Receivable Department.

Assignment

All rights of *members* hereunder are personal to each *member* and are not assignable or otherwise transferable. Neither the Agreement nor any right hereunder shall be assigned, transferred or otherwise conveyed by us without the approval of us. If a *member* desires to assign any rights hereunder, such request shall be evidenced in writing signed by the *member*

and will be granted or denied at our sole discretion. Nothing herein shall be construed to prohibit us from engaging in a corporate reorganization or merger without the consent of the *member*.

Severability

If any term, provision, covenant or condition of this *policy* is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions shall remain in full force and shall in no way be affected, impaired or invalidated.

Conformity with Applicable Laws

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

Personal Health Information

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

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

How to Report Fraud and Abuse

If you suspect one of our providers or *members* of fraud and abuse, please contact Arizona Complete Health toll-free Fraud and Abuse Hotline at 1-800-977-3565. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

Women's Health and Cancer Rights Act of 1998

Surgical services for breast reconstruction and for post-operative *prostheses* incidental to a *medically necessary* mastectomy are covered. Coverage includes:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. *Prostheses* and physical complications for all stages of mastectomy, including lymphedema and at least four external postoperative *prostheses* subject to all of the terms and conditions of the *policy*.