AMBETTER FROM ARKANSAS HEALTH AND WELLNESS

Home Office: One Allied Drive, Suite 2520, Little Rock, AR, 72202

MAJOR MEDICAL EXPENSE COVERAGE
Outline of Coverage for Policy Form 37903AR007
(Please retain this outline of coverage for your records)

Read Your *Policy* Carefully -- This outline sets forth a brief description of the important aspects of your policy. This is not the insurance contract. Only the actual *policy* will control. The *policy* sets forth in detail your and our rights and obligations. For this reason, it is important that you READ YOUR POLICY CAREFULLY!

Major Medical Expense Coverage -- Policies of this type are designed to provide *members* with coverage for the major costs of *hospital*, medical, and surgical care. The cost must be due to a covered *illness* or *injury*. Coverage is provided for daily *hospital* room and board, other *hospital* services, surgical services, anesthesia services, *inpatient* medical services, and out-of-hospital care. Coverage is subject to any *deductible amounts, copayment* provisions, or other limitations that may be set forth in the *policy*.

NOTICE - LIMITED BENEFITS WILL BE PAID WHEN NON-NETWORK PROVIDERS ARE USED.

You should be aware that when you elect to utilize the services of a *non-network provider* for a *covered service* in non-emergency situations, benefit payments to such *non-network provider* are not based upon the amount billed. The basis of your benefit payment will be determined according to the *eligible expense*, as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. *Non-network providers* may bill insureds for any amount up to the billed charge after the plan has paid its portion of the bill. *Network providers* have agreed to discounted pricing for covered expenses with no additional billing for those *covered expenses* to the insured other than *coinsurance* and *deductible amounts*. *Network providers* have not agreed to any discounted pricing for non-covered expenses. You may obtain further information about: (1) the participating status of professional providers by calling the toll-free telephone number on your member identification card; and (2) information on *out-of- pocket expenses* by calling our customer service number listed on your *member* identification card.

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

GUARANTEED RENEWABLE

Annually, we must file this product, the cost share and the rates associated with it for approval. Guaranteed renewable means that your plan will be renewed into the subsequent year's approved product on the anniversary date unless terminated earlier in accordance with *policy* terms. You may keep the *policy* (or the new *policy* you are mapped to for the following year) in force by timely payment of the required premiums. In most cases you will be moved to a new

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

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

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

At least 31 calendar days' notice of any plan to take 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 the *policy* or a change in a *member's* health. While the *policy* is in force, we will not restrict coverage already in force. Changes to the *policy* will be approved by the Arkansas Insurance Department.

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

For All Covered Persons

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

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

If you have material modifications (examples include a change in life event (marriage, death) or family status), or questions related to your health insurance coverage, contact the Health

Insurance Marketplace at www.healthcare.gov or 1-800-318-2596. If you enrolled through Ambetter contact the Member Services Department.

For Dependent Members

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

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

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

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

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

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

INTRODUCTION

Welcome to Ambetter from Arkansas Health & Wellness! We have prepared the *policy* to help explain your coverage. Please refer to the *policy* whenever you require medical services. It describes:

1. How to access *medical care*.
2. The health care services we cover.
3. The portion of your health care costs you will be required to pay.

The *policy,* your *Schedule of Benefits*, the application as submitted to the Health Insurance Marketplace or QualChoice Life & Health Insurance Company and any amendments or riders attached shall constitute the entire *policy* under which *covered services* and supplies are provided or paid for by us.

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

How to Contact Us

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

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. local time, Monday through Friday
Member Services 1-877-617-0390
TTY line 1-877-617-0392
Fax 1-877-617-0393
Emergency **911**
24/7 Nurse Advice Line 1-877-617-0390 or for hard of hearing (TTY 1-877-617-0392)

Interpreter Services

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

To arrange for interpretation services, please call Member Services.

COST SHARING FEATURES

Cost Sharing Features

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

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

Deductible

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

The amount payable will be subject to:

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

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

Copayments

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

Coinsurance Percentage

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

supply. *Coinsurance amounts* do not apply toward the *deductible* but do apply toward your *maximum out-of-pocket amount*. When the annual *out-of-pocket maximum* has been met, additional *covered services* will be provided at100 percent.

Maximum Out-of-Pocket

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

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

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

If you are a covered *member* in a family of two or more *members*, you will satisfy your *maximum out-of-pocket amount* when:

1. You satisfy your individual *maximum out-of-pocket amount*; or
2. Your family satisfies the family *maximum out-of-pocket amount* for the *calendar year*.

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

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

The amount provided or payable will be subject to:

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

Non-Network Liability and Balance Billing

If you receive services from a *non-network provider*, you may have to pay more for services you receive. *Non-network 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 will not be *balance billed* when *balance billing protections* apply to *covered services*.

ACCESS TO CARE

Primary Care Physician (PCP)

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

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

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

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

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

Your *network PCP* will be responsible for coordinating all covered health services with other *network providers.* You may be required to obtain a referral from a *PCP* in order to receive care from a *specialist physician.* You do not need a referral from your *network PCP* for mental or *behavioral health* services, obstetrical or gynecological treatment, and may seek care directly from a *network* obstetrician or gynecologist.

Changing Your PCP

You may change your *network PCP* for any reason, but not more frequently than once a month, by submitting a written request, online at our website at Ambetter.ARHealthWellness.com, or by contacting our office at the number shown on your

identification card. The change to your *network PCP* of record will be effective no later than 30 calendar days from the date we receive your request.

Contacting Your PCP

To make an appointment with your *PCP*, call his/her office during business hours and set up a date and time. If you need help, call Member Services at 1-877-617-0390 and we will help you make an appointment. If you need to cancel or change your appointment, call 24 hours in advance. At every appointment, make sure you bring your *member* ID and a photo ID. Should you need care outside of your *PCP*'s office hours, you should call your *PCP*'s office for information on receiving after hours care in your area. If you have an urgent medical problem or question or cannot reach your *PCP* during normal office hours, call our 24/7 nurse advice line. A licensed nurse is always available and ready to answer your health questions. In an *emergency*, call 911 or head straight to the nearest emergency room.

Service Area

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

Coverage Under Other Policy Provisions

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

Continuity of Care

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

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

1. When a *member* is enrolled in an Ambetter plan and is being treated by a *non-network provider* for a current episode of an acute condition, the *member* may continue to

receive treatment as a *network* benefit from that provider until the current episode of treatment ends or until the end of ninety (90) days, whichever occurs first; and

2. When a provider's participation is terminated, the provider's patients under the plan may continue to receive care from that provider as a *network* benefit until a current episode of treatment for an acute condition is completed or until the end of ninety (90) days, whichever occurs first.

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

Emergency Services Outside of Service Area

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

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

Non-Emergency Services Outside of Service Area

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

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

Hospital Based Providers

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

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*.

New Technology

Health technology is always changing. If we think a new medical advancement can benefit our members, we evaluate it for coverage. These advancements include:

1. New technology
2. New medical procedures
3. New drugs
4. New devices
5. New application of existing technology

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

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

Preferred Partnership

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

MAJOR MEDICAL EXPENSE BENEFITS

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

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

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

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 include.

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

Treatment for an *Acquired Brain Injury* may be provided at a *hospital*, an acute or post-*acute rehabilitation hospital*, an assisted living facility or any other facility at which appropriate services or therapies may be provided. Service means the work of testing, treatment, and providing therapies to an individual with an *Acquired Brain Injury*. Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an *Acquired Brain Injury*.

To ensure that appropriate post-acute care treatment is provided, the *policy* includes coverage for expenses related to periodic reevaluation of the care of an individual covered who:

1. Has incurred an *Acquired Brain Injury*;
2. Has been unresponsive to treatment;

3. Is medically stable; and
4. To ensure that appropriate post-acute care treatment is provided, the *policy* includes coverage for expenses related to periodic reevaluation of the care of an individual covered with the expectation 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.

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

Ambulance Services

Ambulance Service Benefits (Ground and Water)

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

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

Benefits for ambulance services are limited to:

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

Prior authorization is not required for *emergency* ambulance transportation. **Note:** Non-*emergency* ambulance transportation requires *prior authorization*. You should not be *balance billed* for services from a non-network ambulance provider, beyond your *cost share*, for ground and water ambulance services.

Unless otherwise required by Federal or Arkansas law, if you receive services from *non-network* ambulance providers, you may be *balance billed*.

Exclusions

No benefits will be paid for:

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

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

7. In cases where the *member* is experiencing an *emergency condition*, to the nearest *hospital* that can provide services appropriate to treat the *member's emergency* condition.
8. 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.
9. Transportation between *hospitals* or between a *hospital* and a *skilled nursing*, *rehabilitation facility* and member's home when *authorized* by *Ambetter*.
10. When ordered by an employer, school, fire or public safety official and the *member* is not in a position to refuse; or
11. When a *member* is required by us to move from a *non-network provider* to a *network provider*.

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

Limitations
Benefits for air ambulance services are limited to:

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

Exclusions
No benefits will be paid for:

1. Air ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-*emergency* medical transportation.
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).

Autism Spectrum Disorder Benefits

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

1. evaluation and assessment services;
2. *applied behavior analysis* therapy;
3. behavior training and behavior management;
4. speech therapy;

5. occupational therapy;
6. physical therapy;
7. psychiatric care such as counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor or clinical social worker; and
8. medications or nutritional supplements used to address symptoms of *autism spectrum disorder.*

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

Applied Behavior Analysis has the following service minimums:

1. *Applied Behavior Analysis* Treatment Plan: Three hours every three months;
2. *Applied Behavior Analysis* Testing: Three hours every three months;
3. *Applied Behavior Analysis* Supervision: Six hours per week for 50 weeks;
4. *Applied Behavior Analysis* Direct Line Service: 24 hours per week for 50 weeks

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

Covered expenses for a *member* shall include mammography screenings in accordance with USPSTF A and B rated guidelines and applicable state law. Breast ultrasounds are not subject to *deductible amount, coinsurance amount* and *copayment amount* requirements. In addition, your *cost sharing* requirement for a *diagnostic examination for breast cancer*, including *breast magnetic resonance imaging*, will be the same or less than the *cost sharing* requirement for a screening examination for breast cancer.

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 registered nurses or social workers that are specially trained to help you*:*

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

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

If you think you could benefit from our *Care Management* program, please call Member Services.

Chelation Therapy

Covered expenses for chelation therapy for control of ventricular arrhythmias or heart block associated with digitalis toxicity, *emergency* treatment of hypercalcemia, extreme conditions of

metal toxicity, including thalassemia intermedia with hemosiderosis, Wilson's disease (hepatolenticular degeneration), lead poisoning and hemochromatosis is covered.

Chiropractic Services

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

Clinical Trial Coverage

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

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

Clinical trials must meet the following requirements:

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

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

1. One of the National Institutes of Health (NIH);
2. The Centers for Disease Control and Prevention;
3. The Agency for Health Care Research and Quality;
4. The Centers for Medicare & Medicaid Services;
5. A cooperative group or center of any of the entities listed above or the Department of Defense or the Department of Veteran Affairs;
6. An NIH Cooperative Group or Center;
7. The FDA in the form of an *investigational* new drug application;
8. The federal Departments of Veterans' Affairs, Defense, or Energy;

9. An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects;
10. The study or investigation is a drug trial that is exempt from having such an *investigational* new drug application; or
11. A qualified non-governmental research entity that meets the criteria for NIH Center support grant eligibility.

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

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

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

Craniofacial Corrective Surgery and Related Expenses

Covered expenses shall include *craniofacial corrective surgery* and related *medical care* for a person of any age who is diagnosed as having a *craniofacial anomaly*, provided that the *surgery* and treatment are *medically necessary* to improve a functional impairment that results from the *craniofacial anomaly* as determined by the American Cleft Palate-Craniofacial Association in Chapel Hill, North Carolina.

A nationally accredited cleft-craniofacial team for cleft-craniofacial conditions shall:

1. Evaluate a *members* with *craniofacial anomalies*; and
2. Coordinate a treatment plan for each person.

Covered expenses includes the following, if *medically necessary* and if related to the *craniofacial corrective surgery* and included in the treatment plan described above:

1. On an annual basis, sclera contact lenses, office visits, an ocular impression, additional tests or medical procedures that are *medically necessary* for a craniofacial patient;
2. Every two years, two hearing aids and two hearing aid molds for each ear;
3. Every four years, a dehumidifier.

Diabetes Care

Benefits are available for *medically necessary* services and supplies used in the treatment of *members* with gestational, type I or type II diabetes*. Covered expenses* include, but are not limited to:

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

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

Dialysis Services

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

Covered expenses include:

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

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

Disposable Medical Equipment and Supplies

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

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

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

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

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

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

Benefits for repairs and replacement do not include the following:

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

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

Durable medical equipment

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

the equipment is owned by the *member*; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered services may include, but are not limited to:

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

Exclusions

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

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

Durable medical equipment and supplies are subject to *prior authorization* as outlined in the *policy*. Please see your *Schedule of Benefit* for benefit levels or additional limits.

Medical and surgical supplies

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

Covered services may include, but are not limited to:

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

Exclusions

Non *Covered Services* include but are not limited to:

1. Adhesive tape, band aids, cotton tipped applicators.
2. Arch supports.
3. Doughnut cushions.
4. Hot packs, ice bags.

5. Vitamins (except as provided for under **Preventive Care Expense Benefits** provision).
6. Med-injectors.
7. Items usually stocked in the home for general use like band aids, thermometers, and petroleum jelly.

Prosthetics

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

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

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

Covered services may include, but are not limited to:

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

treatment or injury. Coverage shall be subject to a written recommendation by the treating physician stating that the wig is *medically necessary*.

10. For *medically necessary* Prosthetic devices for athletics or recreation (includes coverage for a replacement every three years, unless it is *medically necessary* to replace more often).
11. Prosthetic devices for showering or bathing (includes coverage for a replacement every three years, unless it is *medically necessary* to replace more often).

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

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

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

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

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

Orthotic devices may be replaced once per year per Member when *medically necessary* in the *member's* situation. However, additional replacements will be allowed for *members* due to rapid growth, or for any *member* when a device is damaged and cannot be repaired.

Exclusions
Non-*covered services* include but are not limited to:

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

Electrotherapy stimulators

Covered expenses include using Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve *injury* when that pain is unresponsive to medication. Coverage is also provided for Neuromuscular Electrical Stimulation (NMES) for treatment of disuse atrophy where nerve supply to the muscle is intact, including but not limited to atrophy secondary to prolonged splinting or casting of the affected extremity, contracture due to scarring of soft tissue, as in burn lesions and hip replacement *surgery*, until orthotic training begins.

Emergency Services

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

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

Enteral Feedings

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

Family Planning and Contraception Services

All FDA-approved contraception methods (identified on www.fda.gov) are approved for *members* without *cost sharing* when the care is legal under *applicable law*. *Members* have access to the methods available and outlined on our Drug Formulary or Prescription Drug List, located within Ambetter.ARHealthWellness.com under Drug Coverage, without cost share. Some contraception methods are available through a ***member's*** medical benefit, including the insertion and removal of the contraceptive device at no cost share to the *member*. Emergency contraception is available to members without a prescription and at no *cost share* to the *member*. Oral contraceptive coverage is provided in accordance with Affordable Care Act rules. If you are utilizing an oral contraceptive that is not on our formulary or that is on a tier higher than preventive tier, you or your provider can get in touch with our *Prior Authorization* team. Our *Prior Authorization* team will provide you with an override so that non-formulary or non-preferred medication will process at no cost to you.

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

1. Medical history review
2. Physical examinations
3. Laboratory tests related to physical examinations
4. Contraceptive counseling

5. All FDA-approved contraception methods are covered without *cost sharing* as outlined at www.fda.gov (see “Contraception” section above). This benefit contains both pharmaceutical and medical methods, including, but not limited to:
    a. Intrauterine devices (IUD),
    b. Copper intrauterine devices,
    c. Intrauterine devices with progestin (all durations and doses), including insertion and removal;
    d. Barrier methods including: male and female condoms (Rx required from provider, limited to 30 per month),
    e. Diaphragm with spermicide,
    f. Sponge with spermicide,
    g. Cervical cap with spermicide and spermicide alone;
    h. Oral contraceptives including the pill (combined pill and extended/continuous use), and the mini pill (Progestin only),
    i. The contraceptive patch;
    j. Other hormonal contraceptives, including inserted and implanted contraceptive devices, hormone contraceptive injections and
    k. The vaginal contraceptive ring;
    l. *Emergency* contraception (the morning after pill),
    m. *Emergency* contraception (levonorgestrel and ulipristal acetate);
    n. Implantable rods,
    o. Prescription based sterilization procedures for women; and
    p. FDA-approved tubal ligation.
6. Vasectomy and services related to this procedure.

Coverage is also available for:

1. Any additional contraceptives approved, granted, or cleared by the FDA (if the patient and the patient’s attending provider have determined it to be medically appropriate);
2. Contraceptive care, such as: screening, education, provision of contraception, counseling and follow-up care (e.g., management, evaluation and changes, including the removal, continuation and discontinuation of contraceptives);
3. Instruction in fertility awareness-based methods, including lactation amenorrhea.

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

Habilitation Expense Benefits

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

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

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

High Frequency Chest Wall Oscillators

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

Home HealthCare Expense Benefits

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

1. *Home health aide services*;
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for home health care and developmental services associated with developmental delays, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder;
3. Intravenous medication and pain medication (Intravenous medication and pain medication are *covered service* expenses to the extent they would have been *covered service* expenses during an *inpatient hospital* stay);
4. Hemodialysis, and for the processing and administration of blood or blood components;
5. *Necessary medical supplies*; and
6. Rental of *medically necessary durable medical equipment* at the discretion of the plan. At our option, we may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider we authorize before the purchase.

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

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

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

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

Hospice Care Expense Benefits

This provision only applies to a *terminally ill member* receiving *medically necessary* care under a *hospice care program* or in a home setting. *Respite care* is covered on an *inpatient* or home basis to allow temporary relief to family members from the duties of caring for a *member* under *hospice care*. Respite days that are applied toward the *member's deductible amount* are considered benefits provided and shall apply against any maximum benefit limit for these services. Respite care coverage is limited to 14 calendar days per year.

The list of *covered service expenses* includes:

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

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

Exclusions and Limitations
Any exclusion or limitation contained in the *policy* regarding:

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

Hospital Benefits

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

1. Daily room and board.
   a. *Hospital* admissions are subject to pre-admission notification. Please call the number listed on your identification card to notify us of the admission.
   b. Services rendered in a *hospital* in a country outside of the United States of America shall not be paid except at our sole discretion;
   c. Admissions to a long term acute care *hospital* or to a long term acute care division of a *hospital* are subject to pre-admission notification.
2. Daily room and board and nursing services while confined in an *intensive care unit*.
3. *Inpatient* use of an operating, treatment, or recovery room;
4. Outpatient use of an operating, treatment, or recovery room for *surgery;*
5. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatient;*

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

In Vitro Fertilization

Benefits for in vitro fertilization procedures are covered when:

1. The patient is the policyholder or the *spouse* of the policyholder and a covered *dependent member* under the *policy*, and the *member's* oocytes are fertilized with the sperm of the patient's *spouse*, and the patient and the patient's *spouse* have a history of unexplained infertility of at least two years' duration; or
2. The infertility is associated with one or more of the following medical conditions:
    a. Endometriosis;
    b. Exposure in utero to Diethylstilbestrol, commonly known as DES;
    c. Blockage of or removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
    d. Abnormal male factors contributing to the infertility.

In vitro fertilization procedures must be performed at a medical facility, licensed or certified by the Arkansas Department of Health, which conform to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization and the patient has been unable to

obtain successful *pregnancy* through any less costly applicable infertility treatment for which coverage is available under the *policy*.

Benefits for in vitro fertilization shall be provided under infertility treatment provisions and are subject to the same *cost share* obligations and out-of-pocket limitations that apply to maternity benefits. Cryopreservation, the procedure whereby embryos are frozen for late implantation, shall be included as an in vitro fertilization procedure.

Inotropic Agents for Congestive Heart Failure

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

Long Term Acute Care

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

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

1. Complex wound care:
    a. Daily physician monitoring of wound
    b. Wound requiring frequent complicated dressing changes, and possible repeated
    c. debridement of necrotic tissue
    d. Large wound with possible delayed closure, draining, and/or tunneling or high output fistulas
    e. Lower extremity wound with severe ischemia
    f. Skin flaps and grafts requiring frequent monitoring
2. Infectious disease:
    a. Parenteral anti-infective agent(s) with adjustments in dose
    b. Intensive sepsis management
    c. Common conditions include osteomyelitis, cellulitis, bacteremia, endocarditis, peritonitis, meningitis/encephalitis, abscess and wound infections
3. Medical complexity:
    a. Primary condition and at least two other actively treated co-morbid conditions that require monitoring and treatment
    b. Common conditions include metabolic disorders, stroke, heart failure, renal insufficiency, necrotizing pancreatitis, emphysema (COPD), peripheral vascular disease, and malignant/end-stage disease
4. Rehabilitation:
    a. Care needs cannot be met in a rehabilitation or skilled nursing facility
    b. Patient has a comorbidity requiring acute care
    c. Patient is able to participate in a goal-oriented rehabilitation plan of care
    d. Common conditions include CNS conditions with functional limitations, debilitation, amputation, cardiac disease, orthopedic surgery
5. Mechanical ventilator support:
    a. Failed weaning attempts at an acute care facility

b. Patient has received mechanical ventilation for 21 consecutive days for 6 hours or more/per day
c. Ventilator management required at least every 4 hours as well as appropriate diagnostic services and assessments
d. Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions
e. Patient is hemodynamically stable and not dependent on vasopressors
f. Respiratory status is stable with maximum PEEP requirement 10 cm H2O, and FiO2 60% or less with O2 saturation at least 90%
g. Common conditions include complications of acute lung injury, disorders of the central nervous and neuromuscular systems, and cardiovascular, respiratory, and pleural/chest wall disorders
h. Patient continues to meet the criteria above and does not meet the criteria to be transitioned to alternate level of care.

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

Lymphedema Benefit

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

Maternity Care

Coverage for maternity care: outpatient and *inpatient* pre- and post-partum care including examinations, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and *hospital* stays for delivery or other *medically necessary* reasons, less any applicable *deductible amount*, *copayment amount* or *coinsurance*. *Covered services* also include hepatitis C screening during *pregnancy* by a *healthcare professional*, and such screening is not subject to *deductible* or *copayment* requirements. An *inpatient* stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a cesarean delivery. We do not require a *physician* or other healthcare provider to obtain *prior authorization* for the delivery. An *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require *prior authorization. Covered services* also include a screening for depression for the mother within the first six weeks of giving birth by a physician or licensed *healthcare provider* who is attending a birth or providing medical treatment to the mother. If the mother declines the screening within the first six weeks of giving birth, the physician or licensed *healthcare provider* will update the *member's* medical records that the *member* refused the screening for depression.

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

1. Outpatient and *inpatient* pre- and post-partum care, including examinations, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment and childbirth classes;
2. *Physician* home visits and office services;

3. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests;
4. *Complications of pregnancy;*
5. *Hospital* stays for other *medically necessary* reasons associated with maternity care; and
6. Home births performed by a licensed/certified midwife or *healthcare professional*.

Duty to Cooperate. We do not cover services or supplies related to a *member's pregnancy* when a *member* is acting as a *surrogate* and has entered into a *surrogacy arrangement*. For more information on excluded services, please see the **General Limitations and Exclusions** section. *Members* who are a *surrogate* at the time of enrollment or *Members* who agree to a *surrogacy arrangement* during the plan year must, within 30 calendar days of enrollment or agreement to participate in a *surrogacy arrangement*, send us written notice of the *surrogacy arrangement* to Arkansas Health & Wellness at Member Services, Ambetter from Arkansas Health & Wellness P.O. Box 25408, Little Rock, AR 72221. In the event that a *member* fails to comply with this provision, we reserve our right to enforce the *policy* on the bases of fraud, misrepresentation or false information, up to and including recoupment of all benefits that we paid on behalf of the *surrogate* during the time that the *surrogate* was insured under our *policy*, plus interest, attorneys' fees, costs and all other remedies available to us.

Medical and Surgical Expense Benefits

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

1. For surgery in a physician's office, *inpatient* facility, outpatient facility, or a surgical facility, including services and supplies.
2. Made by an assistant surgeon;
3. For pre-surgical and post-surgical procedural testing, including but not limited to diagnostic services using radiologic, ultrasonographic, or laboratory services.
    a. Laboratory tests or radiological examinations done on an outpatient basis in a *hospital* or other facility accepted by the *hospital* before *hospital* confinement or outpatient surgery or procedures; and
    b. The tests must be for the same bodily *injury or illness* causing the *member* to be *hospital* confined or to have the outpatient *surgery* or procedure.
    c. Sleep disorder studies in home or facility
    d. Bone density studies.
    e. Clinical laboratory tests.
    f. Gastrointestinal lab procedures.
    g. Pulmonary function tests.
    h. Genetic testing
    i. For *medically necessary* genetic or molecular cancer testing, including but not limited to, tumor mutation testing, next generation sequencing, hereditary germline mutation testing, pharmacogenomics testing, whole exome, genome sequencing and biomarker testing.
    j. Family planning for certain professional provider contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion or

extraction of FDA-approved contraceptive devices, to the extent such services and supplies are legal under *applicable law*.

4. 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.
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 Durable Medical Equipment (DME), Medical and Surgical Supplies, Orthotic Devices and Prosthetics provision of the *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 an anesthesia, oxygen, drugs, medications, and biologicals.
9. For *medically necessary* reconstructive or cosmetic surgery because of
    a. For 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. An accidental *injury*, which results in damage to his or her natural teeth. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
    b. Surgery to correct a functional defect which results from a congenital and/or acquired disease or anomaly.
    c. Cleft lip and cleft palate for an eligible *member*. *Covered services* includes medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the treating *physician* or surgeon and such physician or surgeon certifies that such services are *medically necessary* and consequent to treatment of the cleft lip or cleft palate.
    d. Dental anesthesia charges include coverage for the administration of general anesthesia and hospital charges for dental care, rendered by a dentist, provided to the following *members*:
        i. A *member* whose treating health care professional, in consultation with the dentist, determines the *member* has a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or
        ii. A *member* who has one or more medical conditions that would create significant or undue medical risk for the individual during delivery of any dental treatment or *surgery* if not rendered in a *hospital* or ambulatory surgical center.
        iii. Necessary dental treatment is that which, if left untreated, is likely to result in a medical condition. Use of general anesthesia in a *hospital* or ambulatory surgical center is subject to *prior authorization* by us. Please call Member

Services to confirm your benefits for the use of general anesthesia in a *hospital* or ambulatory surgical center.

11. For infertility counseling and planning services when provided by a *network* provider and testing to diagnose infertility.
12. For the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.
13. For routine patient care for *members* enrolled in an eligible cancer clinical trial that is deemed an *experimental or investigational* treatment if the services provided are otherwise considered *covered services* under the contract. See Clinical Trial Coverage provision of the *policy*.
14. For the following types of *medically necessary* implants and tissue grafts:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.
    e. Implantable prosthetic lenses, in connection with cataracts.
    f. Skin grafts
15. For X-ray, Magnetic Resonance Imaging (MRI), Computer Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT), and other diagnostic services. See Radiology, Imaging and Other Diagnostic Testing provision of the *policy*.
16. For *medically necessary telehealth services* subject to the same clinical and utilization review criteria, plan requirements and limitations as the same health care services when delivered to a *member* in-person.
17. For *surgery* or services related to cochlear implants and bone anchored hearing aids. See your *Schedule of Benefits* for additional information.
18. For *medically necessary* services for complications arising from medical and surgical conditions.
19. For respiratory, pulmonary, cardiac, physical, occupational, and speech therapy services. Please see Rehabilitation Expense Benefits & Habilitation Expense Benefits provisions of the *policy*.
20. For maternity care services including but not limited to prenatal, postnatal, diagnostic testing, laboratory services, and hospital services.
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 dermatology services which are limited to the following: *medically necessary* minor *surgery*, tests, and office visits provided by a dermatologist who is a *network* provider.
24. For *medically necessary* biofeedback services.
25. For services associated with human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation or transplant procedure.

26. For *medically necessary* chiropractic care or manipulative therapy treatment on an outpatient basis only. See your *Schedule of Benefits* for benefit levels or additional limits. *Covered services* are subject to all other terms and conditions of the *policy*, including the *deductible amount* and *cost sharing* provisions.
27. For all *medically necessary* immunizations, monitoring, screenings, re-screenings, and laboratory testing for a newborn in the early detection, diagnosis and intervention of a condition or disorder. This also includes but not limited to hearing or audiological services, follow up exams, and pulse oximetry.
28. For *medically necessary* allergy testing and treatment including allergy injections and serum.
29. For services of standby physicians are only covered in the event such physician is required to assist with certain high-risk services specified by Ambetter from Arkansas Health & Wellness, and only for such time as such physician is in immediate proximity to the patient;
30. For electronic consultations between a *medical practitioner*, with other involved *medical practitioners*. Benefits include telephone calls or other forms of electronic consultations between a *medical practitioner* and a *member*, or between a *medical practitioner* and another *medical practitioner*;
31. For coverage for gastric pacemakers for *members* diagnosed with gastroparesis, eligible charges and limits are based on *medical necessity* and require *prior authorization*;
32. Hearing Aids (see your *Schedule of Benefits* for additional information);
33. For one auditory brain stem implant for a *member*, when determined *medically necessary*;
34. For implantable osseointegrated hearing aid for *members* with single-sided deafness and normal hearing in the other ear. Coverage is further limited to *members* with:
    a. congenital or surgically induced malformations (e.g. atresia) of the external ear canal or middle ear;
    b. chronic external otitis or otitis media, subject to *prior authorization*;
    c. tumors of the external canal or tympanic cavity; and
    d. sudden, permanent, unilateral hearing loss due to trauma, idiopathic sudden hearing loss, or auditory nerve tumor;
35. For testing and evaluation limited to 15 hours per *member* per year (**NOTE**: limits do not apply when provided for a mental health/substance use disorder diagnosis):
    a. Psychological testing, including but not limited to, assessment of personality, emotionality and intellectual abilities;
    b. Childhood developmental testing, including but not limited to assessment of motor, language, social, adaptive or cognitive function by standardized developmental instruments;
    c. Neurobehavioral status examination, including, but not limited to assessment of thinking, reasoning and judgment;
    d. Neuropsychological testing, including, but not limited to Halstead-Reitan, Luria and WAISR.
36. For coverage for off-label use of intravenous immunoglobulin, also known as “IVG”, to treat individuals diagnosed with pediatric acute-onset neuropsychiatric syndrome (PANS) and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection (PANDAS), or both, in accordance with *applicable law.*
37. For *medically necessary services* made by a *physician* who renders services in a

network urgent care center, including facility costs and supplies;

38. For new intervention (one that is not commonly recognized as a generally accepted standard of medical practice) when it is shown through scientific evidence that the intervention will achieve its intended purpose and will prevent, cure, alleviate or enable diagnosis or detection of a medical condition without exposing the *member* to risks that outweigh the potential benefits. New interventions in the process of phase I, II or III trials are not covered;
39. For oral *surgery* (non-dental related only) is covered for:
    a. Tumors/cysts (excision when attached to the jaws, cheeks, lips, tongue, roof or floor of mouth when a pathological examination is required);
    b. Exostoses (excision of jaws and hard palate);
    c. Celluitis (external incision and a drainage); and
    d. Sinuses, salivary glands or ducts (incision of accessory sinuses, salivary glands or ducts);
40. For reconstructive surgery performed for the correction of a cleft palate, cleft lip, removal of a port-wine stain, hemangioma (only on the face), or for the correction of a congenital abnormality;
41. Therapeutic abortion performed to save the life of the member, or as required by *applicable law*. Any abortion that is illegal under *applicable law* is not a covered service.

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

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

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

Medical Foods

We cover medical foods and formulas for:

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

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

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

Low Protein Modified Food Products

Low-protein food products for treating certain inherited metabolic disease are covered. Inherited metabolic diseases are diseases caused by an inherited abnormality of body chemistry. Low-protein food products are foods that are especially formulated to have less than 1 gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. Low protein food products do not include natural foods that are naturally low in protein. *Covered expenses* shall include *medically necessary medical foods* (food products and formulas) for the therapeutic treatment of a *member* inflicted with an inherited metabolic disorder involving a failure to properly metabolize certain nutrients. The *medical foods* must be prescribed by a licensed healthcare provider.

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

1. Phenylketonuria (PKU)
2. Maple Syrup Urine Disease (MSUD)
3. Methylmalonic Acidemia (MMA)
4. Isovaleric Acidemia (IVA)
5. Propionic Acidemia
6. Glutaric Acidemia
7. Urea Cycle Defects
8. Tyrosinemia
9. Nitrogen metabolism disorder
10. Homocystinuria
11. Citrullinemia
12. Argininosuccinic acidemia
13. Very-long-chain acyl-CoA dehydrogenase deficiency
14. Long-chain 3-hydroxyacyl-CoA dehydrogenase deficiency
15. Trifunctional protein deficiency
16. 3-methylcrotonyl CoA carboxylase deficiency
17. Methlmalonic acidemia due to cobalamin A,B defect
18. Ornithine transcarbamylase deficiency
19. Non-ketotic hyperglycinemia
20. Glycogen storage diseases
21. Disorders of creatine metabolism
22. Malonic aciduria
23. Carnitine palmitoyl transferase deficiency type II
24. Glutaric aciduria type II
25. Sulfite oxidase deficiency

Exclusions

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

Medically Necessary 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* and supplies 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. Visual Therapy for adults is excluded.
2. Vision Therapy Development Testing for children, except when pre-approved.
3. Any vision services, treatment or material not specifically listed as a *covered service*.
4. Low vision services and hardware for adults.
5. *Non-network* care, only as defined within this document and *Schedule of Benefits*.
6. Reading glasses for children may be furnished based on the merits of the individual case. The doctor should indicate why such corrections are necessary. All such requests will be reviewed on a *prior authorization* basis.

Mental Health and Substance Use Disorder Benefits

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

Covered services will be provided on an *inpatient* and outpatient basis for the treatment of mental health and *substance use disorder* diagnoses. If you need mental health or *substance use disorder* treatment, you may choose a provider participating in our *behavioral health network* and do not need a referral from your *PCP* in order to initiate treatment.

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

Covered services for mental health and *substance use disorder* are included on a non-discriminatory basis for all *members* for the diagnosis and *medically necessary* and treatment of mental, emotional, and *substance use disorders*, as defined in the *policy*.

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

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

Inpatient

1. *Inpatient* Psychiatric Hospitalization;
2. *Inpatient* Detoxification Treatment;
3. *Inpatient Rehabilitation*;
4. Crisis Stabilization;
5. Residential Treatment facility for mental health and *substance use disorders*; and
6. Electroconvulsive Therapy (ECT);

Outpatient

1. Partial Hospitalization Program (PHP);
2. Intensive *Outpatient* Program (IOP);
3. Mental Health Day treatment;
4. Outpatient detoxification programs;
5. Evaluation and assessment for mental health and *substance use*;
6. Individual and group therapy for mental health and *substance use disorders*;
7. Medication Assisted Treatment – combines behavioral therapy and medications to treat *substance use disorders*;
8. Medication management services;
9. Psychological and Neuropsychological testing and assessment;
10. *Applied Behavior Analysis* for treatment of *Autism Spectrum disorders*;
11. *Telehealth (individual/family therapy; medication monitoring; assessment and evaluation)*;
12. Electroconvulsive Therapy (ECT); and
13. *Transcranial Magnetic Stimulation (TMS)*.

We oversee the delivery and oversight of covered *behavioral health* services for Ambetter from Arkansas Health & Wellness. If you need mental health or *substance use disorder* treatment, you may choose any provider participating in our *behavioral health* and *substance use* provider *network* and do not need a referral from your *PCP* in order to initiate treatment. You can search for *network Behavioral Health* providers by using our Find a Provider tool at Ambetter.ARHealthWellness.com or by calling Member Services. *Deductible amounts, copayment, or coinsurance amounts* and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health services benefits.

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* and specific benefit.

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.

Neurological Rehabilitation Facility Services

Covered expenses for *neurologic rehabilitation facility* services are limited to:

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

Exclusions and Limitations

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

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

Newborns' and Mothers' Health Protection Act Statement of Rights

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

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

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

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

Medical Dental Services

Coverage is provided for:

1. For *medically necessary* oral surgery, including 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. Treatment for Temporomandibular Joint Disorder (TMJ), including removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services.
d. Treatment of non-dental lesions, such as removal of tumors and biopsies.
e. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
f. 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.
g. 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.

2. Dental anesthesia charges include coverage for the administration of general anesthesia and hospital or office charges for dental care, rendered by a dentist, regardless of whether the services are provided in a *network hospital*, surgical center or office, provided to the following members:
   a. A member who is determined by two (2) dentists to require without delay necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; or
   b. a person who has a diagnosed serious mental or physical condition; or
   c. a person with a significant behavioral problem (as certified by the member's physician).
3. For dental service expenses when a member suffers an injury, that results in damage to his or her natural teeth. Injury to the natural teeth will not include any injury as a result of chewing.
4. For surgery, excluding tooth extraction, to treat craniomandibular disorders, or malocclusions.

Outpatient Medical Supplies Expense Benefits

Covered expenses for outpatient medical supplies are limited to charges:

1. For artificial eyes and polishing of such, for larynx, breast prosthesis, or basic artificial limbs but not the replacement thereof, unless required by a physical change in the *member* and the item cannot be modified. If more than one *prosthetic device* can meet a *member's* functional needs, only the charge for the most cost effective *prosthetic device* will be considered a *covered expense.* Coverage provided for eligible charges shall be no less than eighty percent of Medicare allowable as defined by the Centers for Medicare & Medicaid Services, Healthcare Common Procedure Coding System;
2. For *medically necessary* foot orthotics, *prior authorization* may be required;
3. For rental of *medically necessary durable medical equipment*;
4. For the rental of one Continuous Passive Motion (CPM) machine per *member* following a covered joint *surgery*;
5. For a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic *injury* or corneal disease, infectious or non-infectious, and (2) For one pair of eyeglasses or contact lenses per *member* following a covered cataract *surgery*. See your *Schedule of Benefits* for benefit levels or additional limits; and

6. For the cost of a monofocal lens, if the multifocal lens is implanted after a cataract extraction.
7. For infusion therapy.

Pediatric Vision Expense Benefits – Children under the age of 19

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

1. Routine ophthalmological examination
    a. Refraction;
    b. Dilation;
2. Standard Frames
3. Prescription lenses
    a. Single;
    b. Bifocal;
    c. Trifocal;
    d. Lenticular.
4. Additional lens options (including coating and tints)
    a. Progressive lenses (standard or premium);
    b. Intermediate vision lenses;
    c. Blended segment lenses;
    d. Hi-Index lenses;
    e. Plastic photosensitive lenses;
    f. Photochromic glass lenses;
    g. Glass-grey #3 prescription sunglass lenses;
    h. Fashion and gradient tinting;
    i. Ultraviolet protective coating;
    j. Polarized lenses;
    k. Scratch resistant coating;
    l. Anti-reflective coating (standard, premium or ultra);
    m. Oversized lenses;
    n. Polycarbonate lenses.
5. Eye Glass repair if glasses were originally covered under the *policy*.
6. Replacement of lost or broken glasses, only one time within a year.
7. Contact lenses and contact lens fitting fee (in lieu of glasses).
8. Low vision evaluation/aids.
9. Eyeglasses for children diagnosed as having the following diagnoses must have a surgical evaluation in conjunction with supplying eyeglasses:
    a. Ptosis (droopy lid);
    b. Congenital cataracts;
    c. Exotropia or vertical tropia;
    d. Children between the ages of 12 an 21 exhibiting exotropia;
10. Vision therapy developmental testing
    a. Orthoptic and pleoptic training with continuing medical direction and evaluation;
    b. Sensorimotor examination with multiple measurements of ocular deviation (e.g. restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure;
    c. developmental testing extended (includes assessment of motor, language, social,

adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report.

11. Eye prosthesis and polishing services.

Please refer to your *Schedule of Benefits* for a detailed list of *member cost sharing*, annual *maximum out-of-pocket* and appropriate service limitations. To see which vision providers are part of the *network,* please visit Ambetter.ARhealthwellness.com or call Member Services.

Services not covered:

1. Deluxe frame/frame upgrade;
2. Two pair of glasses as a substitute for bifocals; and
3. LASIK *surgery*.

Positron Emission Tomography

Covered expenses shall include coverage for *positron emission tomography* to screen for or to diagnose cancer in a patient upon the recommendation of the patient's *physician* when the patient has a prior history of cancer.

Prescription Drug Expense Benefits

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

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

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

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

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

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

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

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

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

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

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

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance, unless listed on the formulary;
2. For immunization agents otherwise not required under the Affordable Care Act;
3. For medication that is to be taken by the *member,* in whole or in part, at the place where it is dispensed;
4. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals;
5. For a refill dispensed more than 12 months from the date of a *physician's* order;
6. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs;
7. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are listed on the formulary. This exclusion does not apply to prescribed FDA approved contraceptive methods;
8. For drugs labeled "Caution - limited by federal law to *investigational* use" or for *investigational* or *experimental* drugs;
9. For more than a 30-day supply when dispensed in any one prescription or refill, or for some maintenance drugs up to a 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply *network.* Specialty drugs and other select drug categories are limited to 30-day supply when dispensed by retail or mail

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

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

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

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

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

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

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

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

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

Mail Order Pharmacy
Mail Order Pharmacy offers a convenient way to receive your prescriptions. Eligible prescriptions will be safely delivered right to your door at no extra charge to you. You will still be responsible for your regular *copayment/coinsurance*. To enroll for mail order delivery or for any additional questions, please refer to our Ambetter website, click on "For Members," followed by "Drug Coverage." Under the "Mail Order" section, you will find details on your in-network mail order pharmacies and next steps for enrollment.

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

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

For the most current Ambetter Formulary or Prescription Drug List or for more information about our pharmacy program visit Ambetter.ARHealthWellness.com (under “for Member”, “Drug Coverage”) or call Member Services.

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

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

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

Step Therapy for Prescription Drugs
Our *policy* uses a requirement of Step Therapy for certain *prescription drugs*. We employ clinical pharmacists who review, research and analyze the efficacy and value of various drugs. Based on their reviews of clinical practice guidelines and recommended treatment of diseases, they recommend specific drugs as the first ones to try when a *member* begins or requires a change in medication therapy. For most people, these medications work well. In the limited instances where one of these medications is not effective and/or appropriate for a particular *member*, the prescribing *physician* contacts us about approving coverage for a different medication. Trying medications in this “step-by-step” fashion is called Step Therapy. This also ensures that drugs are used in the appropriate clinical order for your medical condition.

Prescription Drug Exception Process

Standard exception request

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

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

Expedited exception request

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

External exception request review

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

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

Preventive Care Expense Benefits

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

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

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

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

Certain services can be performed for preventive or diagnostic reasons (e.g., mammograms). If a service is deemed preventive care and is appropriately reported/billed, it will be covered under the preventive care services benefit. However, when a service is performed for diagnostic purposes and reported/billed accordingly, it will be considered a non-preventive medical benefit and appropriate cost share will apply. **Note:** If preventive and diagnostic services are performed during the same visit, applicable cost share will be taken for the latter.

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

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

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

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

Prostate Specific Antigen Testing

Prostate cancer screening coverage includes one screening per year for any man 40 years of age or older, in accordance with the National Comprehensive Cancer Network guidelines.

Radiology, Imaging and Other Diagnostic Testing

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

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

Rehabilitation Expense Benefits

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

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

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

Care ceases to be *rehabilitation* upon our determination of any of the following:
1. The *member* has reached *maximum therapeutic benefit*;
2. Further treatment cannot restore bodily function beyond the level the *member* already possesses;
3. There is no measurable progress toward documented goals; and
4. Care is primarily *custodial care*.

Second Medical Opinion

Members are entitled to a second medical opinion under the following conditions:
1. Whenever a minor *surgical procedure* is recommended to confirm the need for the procedure;
2. Whenever a serious *injury* or *illness* exists; or
3. Whenever you find that you are not responding to the current treatment plan in a satisfactory manner.

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

Skilled Nursing Facility Expense Benefits

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

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

Sleep Studies

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

Social Determinants of Health Supplemental Benefits

Social determinants of health supplemental benefits and services may be offered to members to remove barriers to accessing health services and improve overall health outcomes. These are benefits and services that we may make available in connection with the *policy*. The benefits and services provided may include transportation to health services, assistance with childcare, access to healthy meals, and other relevant services based on need. The benefits are available as long as coverage remains active, unless changed by us. Upon termination of coverage, the benefits are no longer available. All *members* are eligible for the benefits upon

obtaining coverage. The services are optional, and the benefits are made available at no additional cost to the *member*. The benefits and services available at any given time are made part of the *policy* by this reference and are subject to change by us through an update to information available on our website or by contacting us.

Social determinants of health benefits and services may be offered to *members* through the "My Health Pays" wellness program and through our website. Members may receive notifications about available benefits and services through emails and/or through the "My Health Pays" notification system. To inquire about these benefits and services or other benefits available, you may visit our website at Ambetter.ARHealthWellness.com or by contacting Member Services.

Temporomandibular Joint Disorder and Craniomandibular Disorder Expense Benefits

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

Transplant Services

Covered expenses for transplant service expenses:
Transplants are a *covered service* when a *member* is accepted as a transplant candidate and pre-*authorized* in accordance with the *policy*. *Prior authorization* must be obtained through the "*Center of Excellence"*, before an evaluation for a transplant. We may require additional information such as testing and/or treatment before determining *medical necessity* for the transplant benefit. *Authorization* must be obtained prior to performing any related services to the transplant *surgery*. Transplant services must meet medical criteria as set by Medical Management Policy.

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

1. If both the donor and recipient have coverage provided by the same insurer, each will have their benefits paid by their own coverage program.
2. If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under the *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 the *policy* will be provided for you. However, no benefits will be provided for the recipient.
4. If lapse in coverage due to non-payment of premium, no services related to transplants will be paid as a *covered service*.

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

1. Pre-transplant evaluation;
2. Pre-transplant harvesting;
3. Left Ventricular Assist Devices (LVAD) (only when used as a bridge to a heart transplant);
4. Outpatient *covered services* related to the transplant *surgery*, pre-transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection, and other immunosuppressive drug therapy, etc.;
5. Pre-transplant stabilization, meaning an *inpatient* stay to *medically stabilize* a *member* to prepare for a later transplant, whether or not the transplant occurs;
6. The transplant itself, including the acquisition cost for the organ or bone marrow when authorized through the Center of Excellence and services are performed at a participating facility;
7. Post-transplant follow-up visits and treatments;
8. Donor testing if the donor is found compatible;
9. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors; and
10. All costs incurred and medical expenses by the donor shall be paid under the transplant recipient policy, this excludes travel, lodging, food, and mileage. Please refer to the "Member Transplant Travel Reimbursement Policy" for outlined details on reimbursement limitations. (https://ambetter.arhealthwellness.com/resources/handbooks-forms.html).

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

Ancillary "Center of Excellence" Service Benefits:

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

1. We will pay for the following services when the *member* is required to travel more than 60 miles from the *residence* to the *Center of Excellence*:
2. We will pay a maximum of $10,000 per transplant service for the following services:
    a. Transportation for the *covered person,* any live donor, and the *immediate family* to accompany the *member* to and from the *Center of Excellence,* in the United States*.*
    b. When *member* and/or donor is utilizing their personal transportation vehicle, a mileage log is required for reimbursement.
    c. Maximum reimbursement for mileage is limited to travel to and from the member's home to the transplant facility, and to and from the donor's home to the transplant facility, and will be reimbursed at the current IRS mileage standard for miles driven for medical purposes.
    d. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *member* while the *member* is confined in the *Center of Excellence* in the United States*.* We will reimburse members for the proof of costs directly related for transportation, lodging, and any of the following

approved items listed in the *member* transplant reimbursement guidelines. However, you must make the arrangements and provide the necessary paid receipts for reimbursement within six months of the date of service in order to be reimbursed.

e. Incurred costs related to a certified/registered service animal for the transplant *member* and/or donor.
f. Please refer to the *member* resources page for *member* reimbursement transplant travel forms and information at Ambetter.ARHealthWellness.com.

Non-Covered Services and Exclusions

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

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *medically necessary* transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the Center of Excellence.
4. To keep a donor alive for the transplant operation, except when authorized through the Center of Excellence.
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
6. Related to transplants unauthorized through the Center of Excellence and is not included under this provision as a transplant.
7. The acquisition cost for the organ or bone marrow, when provided at an unauthorized facility or not obtained through the Center of Excellence.
8. For any transplant services and/or travel related expenses for the *member* and donor, when performed outside of the United States.
9. The following ancillary items listed below, will not be subject to *member* reimbursement under the *policy*:
    a. Alcohol/Tobacco
    b. Car Rental (unless pre-approved by Case Management)
    c. Vehicle Maintenance for motorized, hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.)
    d. Parking, such as but not limited to hotel, valet or any offsite parking other than *hospital*.
    e. Storage rental units, temporary housing incurring rent/mortgage payments.
    f. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
    g. Speeding tickets.
    h. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
    i. For any services related to pet care, boarding, lodging, food, and/or travel expenses; other than those related to certified/registered service animal(s).
    j. Expenses for persons other than the patient and his/her covered companion
    k. Expenses for lodging when *member* is staying with a relative
    l. Any expense not supported by a receipt
    m. Upgrades to first class travel (air, bus, and train)
    n. Personal care items (e.g., shampoo, deodorant, clothes)

o. Luggage or travel related items including passport/passport card, REAL ID travel IDs, travel insurance, TSA pre-check, and early check-in boarding fees, extra baggage fees
p. Souvenirs (e.g., t-shirts, sweatshirts, toys)
q. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type
r. All other items not described in the *policy* as *eligible expenses*
s. Any fuel costs/charging station fees for electric cars.

Trans-telephonic Home Spirometry

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

Urgent Care Service Benefits

Urgent care services include *medically necessary* services by *network* providers and services provided at an *urgent care center* including facility costs and supplies. Care that is needed after a *PCP's* normal business hours is also considered to be urgent care. Please refer to your *Schedule of Benefits* for the *cost sharing* applicable to urgent care services. Please note: Your zero *cost sharing* Preventive Care Benefits may not be used at an *urgent care center*.

Members are encouraged to contact their *PCP* for an appointment before seeking care from another provider, but contracted *urgent care centers* and walk in clinics can be used when an urgent appointment is not available. If the *PCP* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-877-617-0390 (TTY 1--877-617-0392). The 24/7 Nurse Advice Line is available 24 hours a day, seven days a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

Wellness and Other Program Benefits

Benefits may be available to *members* for participating in certain programs that we may make available in connection with the *policy*. Such programs may include wellness programs and disease or *care management* programs. These programs may include a reward or an incentive, which you may earn by completing different activities.

If you have a medical condition that may prohibit you from participating in these programs, 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 may obtain information regarding the particular programs available at any given time by visiting our website at Ambetter.ARHealthWellness.com or by contacting Member Services by telephone. The benefits are available as long as coverage remains active, unless changed by us as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available. All *members* are automatically eligible for program benefits upon obtaining coverage. The programs are optional, and the benefits are made available at no additional cost to the *members*. The programs and benefits available at any given time are made part of the *policy* by this reference and are subject to change by us through updates available on our website or by contacting us.

GENERAL LIMITATIONS AND EXCLUSIONS

No benefits will be paid for:

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

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of the *policy*;
2. For any portion of the charges that are in excess of the *eligible expense;*
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery,* bariatric *surgery;*
4. For weight loss programs, gym memberships, exercise equipment or meal preparation programs;
5. For cosmetic breast reduction or augmentation (does not include reduction mammoplasty or gender dysphoria when deemed *medically necessary* by us);
6. For the reversal of sterilization and the reversal of vasectomies;
7. For *abortion*, except as described in the Medical and Surgical Expense Benefits provision under the Major Medical Expense Benefits section.
8. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered expenses* of the Medical Benefits provision;
9. For expenses for television, telephone, or expenses for other persons;
10. For telephone consultations between providers, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment;
11. For stand-by availability of a *medical practitioner* when no treatment is rendered;
12. For *dental expenses,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Medical Benefits;
13. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth

defect as described in the Medical and Surgical Expense Benefits provision under the Major Medical Expense Benefits section;

14. For mental health examinations and services involving:
    a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody, disability, or fitness for duty/return to work, unless a *network physician* determines such evaluation to be *medically necessary*;
    b. When ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless a *network physician* determines such services to be *medically necessary*;
    c. Testing of aptitude, ability, intelligence or interest; and
15. Services which are custodial in nature. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Expense Benefits;
16. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism;
17. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services, unless expressly provided for by the *policy*;
18. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in the *policy*;
19. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the *policy*;
20. Vehicle installations or modifications, which may include, but are not limited to: adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices;
21. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition;
22. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency;
23. *Surrogacy Arrangement*. Health care services, including supplies and medication, to a *surrogate*, including a *member* acting as a *surrogate* or utilizing the services of a *surrogate* who may or may not be a *member*, and any child born as a result of a *surrogacy arrangement*. This exclusion applies to all health care services, supplies and medication to a *surrogate* including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the *surrogate* following childbirth);
    d. Mental health services related to the *surrogacy arrangement*.
    e. Expenses relating to donor semen, including collection and preparation for implantation;

f. Donor gamete or embryos or storage of same relating to a *surrogacy arrangement*;
g. Use of frozen gamete or embryos to achieve future conception in a *surrogacy arrangement*;
h. Preimplantation genetic diagnosis relating to a *surrogacy arrangement*;
i. Any complications of the child or *surrogate* resulting from the *pregnancy*; or
j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*.
k. Any and all 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 where the child is the adoptive child of *members* possessing an active *policy* with us and/ or the child possesses an active *policy* with us at the time of birth.

24. For fetal reduction *surgery*;
25. For expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health, except as specifically identified as a *covered expense* under the *policy*;
26. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or semi-professional sports; intercollegiate sports not including intramural sports; racing or speed testing any motorized vehicle or conveyance, if the *member* is paid to participate or to instruct; racing or speed testing any non-motorized vehicle or conveyance, if the *member* is paid to participate or to instruct; rodeo sports; horseback riding, if the *member* is paid to participate or to instruct; rock or mountain climbing, if the *member* is paid to participate or to instruct; or skiing, if the *member* is paid to participate or to instruct;
27. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *member* is a pilot, officer, or *member* of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft;
28. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of the *member's* enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date;
29. For the following miscellaneous items: artificial insemination except where required by federal or state law; biofeedback; care or complications resulting from non-*covered expenses*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods provision; health club memberships, unless otherwise covered; home test kits, unless required by *applicable law*; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; private duty nursing; *rehabilitation* services for the enhancement of job, athletic or recreational performance; routine or elective care outside the *service area*; treatment of spider veins; transportation expenses; unless specifically described in the *policy*;
30. For diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment. Benefits will be allowed for services that would otherwise be covered under the *policy*;

31. For take-home dressings and supplies following hospitalization; any other supplies, dressings, appliances, devices or services which are not specifically listed as covered above**;** replacement or repair of appliances, devices and supplies due to *loss*, breakage from willful damage, neglect or wrongful use, or due to personal preference;
32. For services or supplies eligible for payment under either federal or state programs (except Medicaid). This exclusion applies whether or not you assert your rights to obtain this coverage or payment of these services;
33. For any claim submitted by non-lock-in pharmacy while *member* is in lock-in status. To facilitate appropriate benefit use and prevent opioid overutilization, member's participation in lock-in status will be determined by review of pharmacy claims;
34. For any medicinal and recreational use of cannabis or marijuana;
35. For expenses or services related to immunizations for travel and occupational purposes, unless otherwise covered under the *policy*;
36. For expenses or services related to massage therapist;
37. For expenses, services and treatments from a Naprapathic specialist for conditions caused by contracted, injured, spasmed, bruised, and/or otherwise affected myofascial or connective tissue.
38. For expenses, services, and treatments from a Naturopathic specialist for treatment of prevention, self-healing and use of natural therapies; or
39. For expenses for services related to dry needling.
40. For expenses or services related to Private Duty Nursing services.
41. For Assertive Community Treatment (ACT).

OUT-OF-AREA PROVIDERS: Except for *dependent members* living outside the *service area*, *members* travelling outside of the *service area* will be responsible for ensuring that their out-of-area *providers* obtain pre-*authorization* to be eligible for benefits for any non-*emergency* health services, including admissions to out-of-area facilities. We apply our medical coverage policies to all requests when evaluating the *medical necessity* for the out-of-area *provider* services, which includes considering the absence of or the exhaustion of all *network* resources. Failure to request pre-*authorization* will result in denial of coverage.