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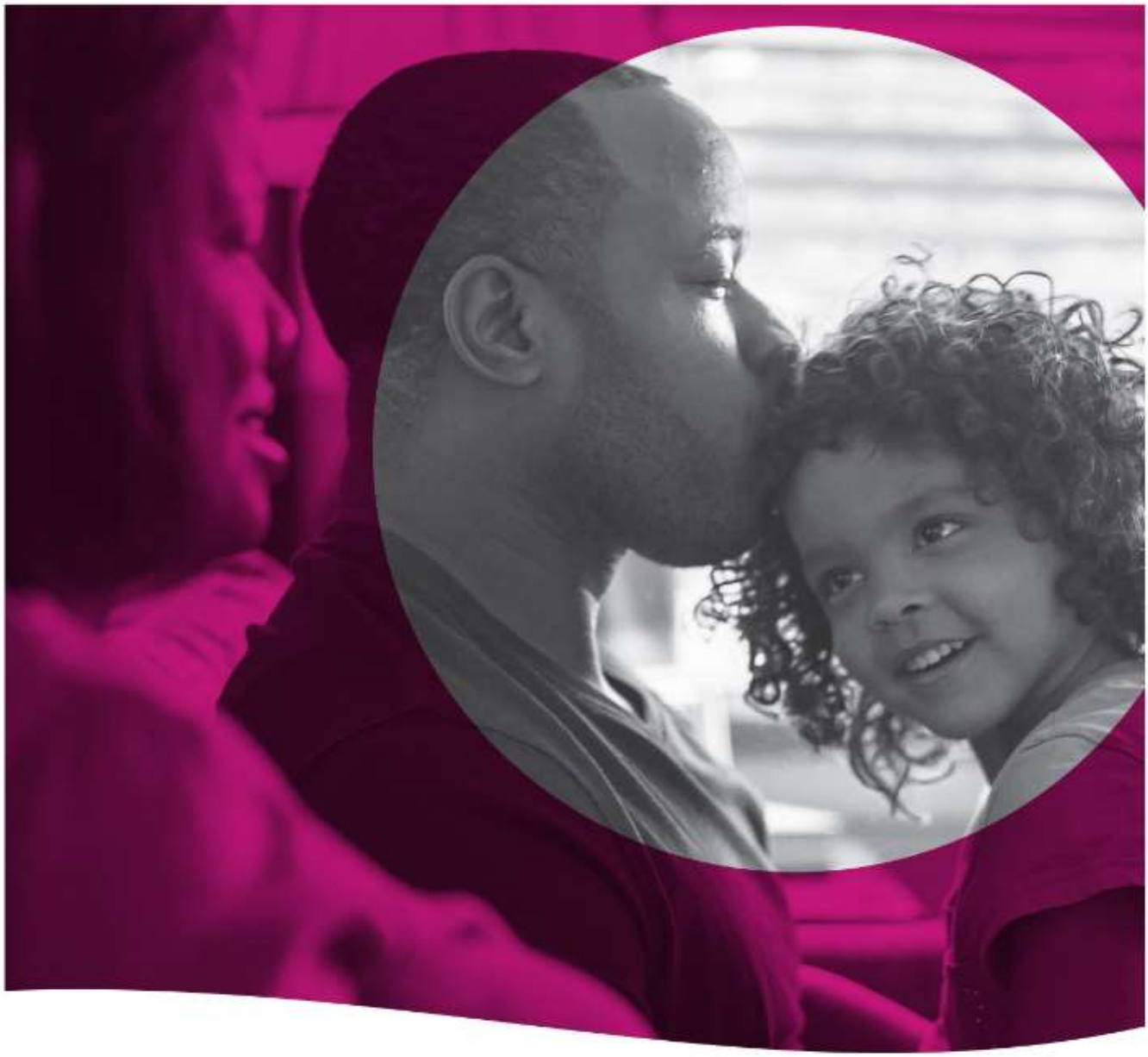
2019 Evidence of Coverage



Ambetter.HomeStateHealth.com

99723MO011-2019

Ambetter from Home State Health
Individual EPO Health Benefit Plan
Issued and Underwritten by Celtic Insurance Company

Home Office: 11720 Borman Drive, St. Louis, MO 63146

Individual Member Contract

In this *contract, "you", "your", "yours" or "member"* will refer to the subscriber and/or any *dependents* enrolled in this contract and *"we," "our,"* or *"us"* will refer to Home State Health.

TEN DAY RIGHT TO RETURN CONTRACT

Please read your *contract* carefully. If you are not satisfied, return this *contract* to us or to our agent within 10 days after you receive it. All premiums paid will be refunded, less claims paid, and the *contract* will be considered null and void from the *effective date*.

AGREEMENT AND CONSIDERATION

We issued this *contract* in consideration of the application and the payment of the first premium. *We* will provide benefits to *you*, the *member*, for covered *losses* due to *illness* or bodily *injury* as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

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

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

From time to time, *we* will change the rate table used for this *contract* form. Each premium will be based on the rate table in effect on that premium's due date. The *policy* plan, and age of *members,* type and level of benefits, and place of *residence* on the premium due date are some of the factors used in determining *your* premium rates. We have the right to change premiums however, all premium rates charged will be guaranteed for a rating period of at least 12 months.

At least 31 days' notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of *claims* made under this *contract* or a change in a *member's* health. While this *contract* is in force, *we* will not restrict coverage already in force.

This health benefit plan requires that all health care services be delivered by a participating provider in *our network*. Services rendered by an out-of-*network* provider are not covered under this plan, except for *emergency services* and two (2) sessions per year to a licensed psychiatrist, licensed psychologist, licensed professional counselor or a licensed clinical worker for the purpose of diagnosis or assessment of mental health.

As a cost containment feature, this *contract* contains *prior authorization* requirements. Benefits may be reduced or not covered if the requirements are not met. Please refer to the *schedule of benefits* and the Prior Authorization Section.

WARNING: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

IMPORTANT INFORMATION

This *contract* reflects the known requirements for compliance under The Affordable Care Act as passed on March 23, 2010. As additional guidance is forthcoming from the US Department of Health and Human Services, and the Missouri Department of Insurance, Financial Institutions and Professional Registration., those changes will be incorporated into your health insurance *contract*.

The coverage represented by this *contract* is under the jurisdiction of the Missouri Department of Insurance, Financial Institutions and Professional Registration.

This contract does not include pediatric dental services. Pediatric dental coverage is included in some health plans, but can also be purchased as a standalone product. Please contact your insurance carrier or producer, or seek assistance through Healthcare.gov, if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

Should this *contract* be purchased Off the Marketplace, then any and all references to Marketplace are not applicable.

Celtic Insurance Company

Anand Shukla,
SVP, Individual Health – Celtic Insurance Company

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INTRODUCTION

Welcome to Ambetter from Home State Health! This *contract* is issued and underwritten by Celtic Insurance Company, and network access and administrative services are provided by Home State Health. We have prepared this *contract* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services. It describes:

- How to access medical care.
- The healthcare services we cover.
- The portion of your healthcare care costs *you* will be required to pay.

This *contract*, the *schedule of benefits*, application as submitted to the Marketplace, and any amendments or riders attached shall constitute the entire contract under which *covered services and supplies* are provided or paid for by *us*.

Because many of the provisions of this *contract* are interrelated, *you* should read this entire *contract* to gain a full understanding of *your* coverage. Many words used in this *contract* have special meanings when used in a healthcare setting – these words are *italicized* and are defined for *you*. Refer to these definitions in the Definitions section for the best understanding of what is being stated. This *contract* also contains exclusions, so please be sure to read this entire *contract* carefully.

How to Contact Us
Ambetter from Home State Health
11720 Borman Drive
St. Louis, MO 63146
Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. CST

Member Services	855-650-3789
TDD/TTY	877-250-6113
Emergency	911
24/7 Nurse Advice Line	855-650-3789

Interpreter Services
Ambetter from Home State Health has a free service to help our *members* who speak languages other than English. This service allows *you* and *your physician* to 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. Members who are blind or visually impaired and need help with interpretation can call Member Services for oral interpretation, or to request materials in Braille or large font.

To arrange for interpreter services, please call Member Services at 1-877-687-1197 (TTY/ TDD 1-877-941-9238).

Members who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation. To arrange for interpretation services, call Member Services at 1-855-650-3789 (TDD/TTY 1-877-250-6113).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

You have the right to:

1. Participate with *your providers* in decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or your legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our* network of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
8. Make recommendations regarding *member's* rights, responsibilities and policies.
9. Voice *complaints* or *appeals* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
11. See *your* medical records.
12. Be kept informed of *covered* and non-covered *services*, program changes, how to access services, *primary care physician* assignment, providers, advance directive information, referrals and *authorizations*, benefit denials, *member* rights and responsibilities, and *our* other rules and guidelines. *We* will notify you at least 31 days before the *effective date* of the modifications. Such notices shall include the following:
    a. Any changes in clinical review criteria; or

b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.

13. A current list of *network providers*.
14. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
15. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual orientation, national origin or religion.
16. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
17. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
18. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *primary care physician*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care physician*. *Your primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
19. Select *your primary care physician* within the *network*. *You* also have the right to change your *primary care physician* or request information on *network providers* close to your home or work.
20. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care physician*.
21. An interpreter when *you* do not speak or understand the language of the area.
22. A second opinion by a *network provider* if you want more information about your treatment or would like to explore additional treatment options
23. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it.
24. Advance directives are forms *you* can complete to protect *your* rights for medical care. It can help your *primary care physician* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney
    c. "Do Not Resuscitate" Orders. Members also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read the entire *contract*.
2. Treat all healthcare professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of your *physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* I.D. card and keep scheduled appointments with *your physician*, and call the *physician*'s office during office hours whenever possible if *you* have a delay or cancellation.
6. Know the name of *your* assigned *primary care physician*. *You* should establish a relationship with *your physician*. You may change your *primary care physician* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or

ask for help if *you* need it.

8. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care physician* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care physician*.
14. Provide all information about any other medical coverage you have upon enrollment in this plan. If, at any time, you get other medical coverage besides this coverage, you must tell the entity with which you enrolled..
15. Pay *your* monthly premium on time and pay all *deductible amounts, copayment amounts*, or *cost-sharing percentages* at the time of service.
16. Inform the entity in which you enrolled for this *policy* if you have any changes to your name, address, or family members covered under this *policy* within 60 days from the date of the event.

Your Provider Directory

A listing of *network providers* is available online at http://ambetter.homestatehealth.com/findadoc. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* with *your* healthcare services. *You* may find any of our *network providers* by completing the "Find a Provider" function. There *you* will have the ability to narrow *your* search by provider specialty, zip code, gender, whether or not they are currently accepting new patients, and languages spoken. *Your* search will produce a list of providers based on *your* search criteria and will give *you* other information such as address, phone number, office hours, and qualifications.

At any time, you can request a copy of the provider directory at no charge by calling Member Services at 1-855-650-3789. In order to obtain benefits, *you* must designate a *primary care provider* for each *member. We* can help *you* pick a *primary care physician* (PCP). We can make your choice of *primary care physician* effective on the next business day.

Call the *primary care physician*'s office if you want to make an appointment. If *you* need help, call Member Services at 1-855-650-3789. *We* will help *you* make the appointment.

Your Member ID Card

When *you* enroll, *we* will mail a member ID card to *you* after *we* receive *your* completed enrollment materials, which includes receipt of *your* initial premium payment. This card is proof that *you* are enrolled in the Ambetter from Home State Health. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under this *contract*.

The ID card will show *your* name, *member* ID#, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1-855-650-3789. *We* will send *you* another card.

Our Website

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

1. Finding a network provider.
2. Our programs and services, including programs to help you get and stay healthy.
3. A secure portal for you to check the status of your claims, make payments and obtain a copy of your Member ID card.
4. Member Rights and Responsibilities.
5. Notice of Privacy.
6. Current events and news.
7. Our Formulary or Preferred Drug List.
8. Selecting a *Primary Care Provider*.
9. *Deductible* and *Co-payment* Accumulators.
10. Making your payment.

Quality Improvement

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

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Monitoring *member* access to all types of healthcare services.
3. Providing programs and educational items about general healthcare and specific diseases.
4. Sending reminders to *members* to get annual tests such as a physical exam, preventive health screenings, and immunizations.
5. Monitoring the quality of care and developing action plans to improve the healthcare *you* are receiving.
6. A Quality Improvement Committee that includes *network providers* to help us develop and monitor our program activities.
7. Investigating any *member* concerns regarding care received.

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

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

DEFINITIONS

In this *contract*, italicized words are defined. Words not italicized will be given their ordinary meaning. Wherever used in this *contract*:

Acute rehabilitation means two or more different types of therapy provided by one or more *rehabilitation* licensed practitioners and performed for three or more hours per day, five to seven days per week, while the *member* is confined as an *inpatient* in a *hospital, rehabilitation facility*, or *extended care facility*.

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

Adverse Benefit Determination means a decision by *us* which results in:

1. A denial of a request for service.
2. A denial, reduction or failure to provide or make payment in whole or in part for a covered benefit.
3. A determination that an admission, continued stay, or other health care service does not meet *our* requirements for *medical necessity*, appropriateness, health care setting, or level of care or effectiveness.
4. A determination that a service is *experimental, investigational, cosmetic treatment,* not *medically necessary* or inappropriate.
5. *Our* decision to deny coverage based upon an eligibility determination.
6. A *rescission* of coverage determination as described in the General Provisions section of this *contract.*
7. A prospective review or retrospective review determination that denies, reduces or fails to provide or make payment, in whole or in part, for a covered benefit.

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

Allogeneic bone marrow transplant or ***BMT*** means a procedure in which bone marrow from a related or non- related donor is infused into the transplant recipient and includes peripheral blood stem cell transplants.

Alcoholism Treatment Facility means a residential or nonresidential facility certified by the Missouri Department of Mental Health for treatment of alcoholism.

Ambulatory review means utilization review of health care services performed or provided in an *outpatient* setting.

Appeal means a written complaint submitted by or on behalf of an enrollee regarding the:

1. Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
2. Determination to rescind coverage;
3. Claims payment, handling or reimbursement for health care services; or

4. Matters pertaining to the contractual relationship between an enrollee and a health carrier;

Applied behavior analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Autism service provider:
(a) Any person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri; or
(b) Any person who is licensed under chapter 337 as a board-certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board-certified behavior analyst.

Autism Spectrum Disorder refers to a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Autologous bone marrow transplant or ***ABMT*** means a procedure in which the bone marrow infused is derived from the same person who is the transplant recipient and includes peripheral blood stem cell transplants.

Authorization **or** ***Authorized*** (also "***Prior Authorization***" or "***Approval***") means *our* decision to approve the medical necessity or the appropriateness of care for an enrollee by the enrollee's PCP or provider group.

Authorized representative means an individual who represents a covered person in an internal appeal or external review process of an adverse benefit determination who is any of the following:

1. A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;
2. A person authorized by law to provide substituted consent for a covered individual; or
3. A family member or a treating health care professional, but only when the covered person is unable to provide consent.

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

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

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

Care Management is a program in which a registered nurse, known as a care manager, assists a *member* through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and healthcare benefits available to a *member*. *Care management* is instituted at the sole option of us when mutually agreed to by the *member* and the *member's physician*.

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of transplants other services such as cancer, bariatric or infertility; and
2. Has agreed with *us* or an entity designated by *us* to meet quality of care criteria on a cost

efficient basis. The fact that a *hospital* is a *network provider* does not mean it is a *Center of Excellence.*

Claimant is the *member* or *member's* authorized representative who has contacted the plan to file a grievance or appeal or who has contacted the Missouri Department of Insurance to file an external review.

Coinsurance means the percentage of *covered service expenses* that *you* are required to pay when *you* receive a service. C*oinsurance* amounts are listed in the *schedule of benefits*. Not all *covered services* have *coinsurance*.

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

Complications of pregnancy **means*:***

1. Conditions whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy and not, from a medical viewpoint, associated with a normal pregnancy. This includes: ectopic pregnancy, spontaneous abortion, eclampsia, missed abortion, and similar medical surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy.
2. An *emergency* caesarean section or a *non-elective caesarean section*.

Concurrent Review means utilization review conducted during a patient's hospital stay or course of treatment.

Contract *or* ***Policy*** when *italicized,* refers to this *contract as* issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

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

Cosmetic treatment means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an *injury*, *illness*, or congenital anomaly. *Cosmetic treatment* does not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect.

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

Cost-sharing reductions lower the amount you have to pay in Deductibles, Copayments and

Coinsurance. To qualify for Cost Sharing Reductions, an eligible individual must enroll in a silver level plan through the Marketplace or be a member of a federally recognized American Indian tribe and/or an Alaskan Native enrolled in a QHP through the Marketplace.

Covered service or ***covered service expenses*** means healthcare services, supplies or treatment as described in this *contract* which are performed, prescribed, directed or authorized by a *physician.* To be a *covered service* the service, supply or treatment must be

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

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

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

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

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

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

1. *You* satisfy *your* individual *deductible amount*; or
2. *Your* family satisfies the family *deductible amount* for the *calendar year.*

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

The *deductible amount* does not include any *copayment amounts.*

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

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

Dependent member means *your* lawful *spouse, civil union partner* and/or an *eligible child*, by blood or law, who is under age 26*.*

Diagnosis of autism spectrum disorders means medically necessary assessments, evaluations, or tests in order to diagnose whether an individual has an autism spectrum disorder.

Drug discount, coupon or ***copay card*** means cards or coupons typically provided by a drug manufacturer to discount the copay or your other out of pocket costs (e.g. deductible or maximum out of

pocket).

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

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

Eligible child means the child of a covered person, if that child is less than 26 years of age. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption; or
4. A child for whom legal guardianship has been awarded to *you* or *your spouse*.

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

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

1. For *network providers:* When a *covered service* is received from a *network provider*, the *eligible service expense* is the contracted fee with that provider.
2. For non-*network providers*:
    a. When a *covered service* is received from a non-*network provider* as a result of an *emergency*, and there is a sufficient number and type of *network providers* to provide a *covered service*, the *eligible expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the provider as payment in full (*you* will not be billed for the difference between the negotiated fee and the provider's charge). However, if the provider has not agreed to accept a negotiated fee with *us* as payment in full, the *eligible expense* is the greatest of the following:
        i. the amount that would be paid under Medicare,
        ii. the amount for the *covered service* calculated using the same method we generally use to determine payments for out-of-network services, or
        iii. the contracted amount paid to in-*network providers* for the *covered service*. If there is more than one contracted amount with in-network providers for the *covered service*, the amount is the median of these amounts.

    b. When a *covered service expense* is received from a *non-network provider* as approved or *authorized* by *us* that is not the result of an *emergency*, and there is a sufficient number and type of *network providers* to provide a *covered service*, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* as payment in full (*you* will not be billed for the difference between the negotiated fee and the provider's charge). If there is no negotiated fee agreed to by the provider with *us,* the *eligible service expense* is the amount that would be paid under Medicare (*you* may be billed for the difference between the amount paid under Medicare and the provider's charge).
    c. When a *covered service* is received from a *non-network provider* and there is an insufficient number or type of *network providers* to provide a *covered service*, regardless of whether it is the result of an *emergency*, the *eligible service expense* is the lesser of (1) the negotiated fee, if any, that has been mutually agreed upon by *us* and the provider; or (2) the amount accepted by the provider (not to exceed the provider's charge). In either

circumstance, *you* will not be billed for the difference between the negotiated or accepted fee, as applicable, and the provider's charge.

Please note: For unanticipated or emergency health care services received in an *in-network* facility from a *non-network provider,* from the time *you* present an emergency medical condition until the time of discharge *you* will only be responsible for *your* standard *cost-sharing* amount. For services received in a non-*network* facility, you may be billed for the difference between the amount paid and the non-*network provider's* charge.

Emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:
(a) Placing the person's health in significant jeopardy;
(b) Serious impairment to a bodily function;
(c) Serious dysfunction of any bodily organ or part;
(d) Inadequately controlled pain; or
(e) With respect to a pregnant *member* who is having contractions:
a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
b. That transfer to another hospital may pose a threat to the health or safety of the pregnant *member* or unborn child;

Emergency service means a health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories: Ambulatory patient services, *Emergency* services, Hospitalization, Maternity and newborn care, Mental health and *substance use disorder* services, including behavioral health treatment, Prescription drugs, Rehabilitative and habilitative services and devices, Laboratory services, Preventive and wellness services, and chronic disease management and pediatric services, including oral and vision care. *Essential Health Benefits* provided within this *contract* are not subject to lifetime or annual dollar maximums.

Experimental or investigational treatment means medical, surgical, diagnostic, or other healthcare services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, *we* determine to be:

1. Administration (*USFDA*) regulation, regardless of whether the trial is subject to *USFDA* oversight;
2. An *unproven service;*
3. Subject to *USFDA* approval, and:
    a. It does not have *USFDA* approval;
    b. It has *USFDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation;
    c. It has *USFDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *USFDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
        iii. Not an *unproven service;* or

d. It has *USFDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *USFDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *member.*

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

Items (3) and (4) above do not apply to phase III or IV *USFDA* clinical trials.

Extended care facility means an institution, or a distinct part of an institution, that:

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

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

Final adverse benefit determination means an adverse benefit determination that is upheld at the completion of our internal appeals process.

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

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

Grievance – see definition for ***Appeal***

Habilitation or ***Habilitation Services*** means health care services that help *you* keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* or *outpatient* settings.

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

Health care provider or provider means a health care professional or facility.

Hearing instrument or ***hearing aid*** means any instrument or device designed, intended, or offered for the purpose of improving a person's hearing and any parts, attachments, or accessories, including ear molds. Batteries, cords, and individual or group auditory training devices and any instrument or device used by a public utility in providing telephone or other communication services are excluded.

Hearing instrument dispenser means a person who is a *hearing care professional* that engages in the selling, practice of fitting, selecting, recommending, dispensing, or servicing of hearing instruments or the testing for means of hearing instrument selection or who advertises or displays a sign or represents himself or herself as a person who practices the testing, fitting, selecting, servicing, dispensing, or selling of hearing instruments.

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

Home health care means care or treatment of an *illness* or *injury* at the *member's* home that is:

1. Provided by a *home health care agency*; and
2. Prescribed and supervised by a *physician*.

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

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

Hospice means an institution that:

1. Provides a *hospice care program*;
2. Is separated from or operated as a separate unit of a *hospital, hospital*-related institution, *home health care agency,* mental health facility, *extended care facility,* or any other licensed health care institution;
3. Provides care for the *terminally ill;* and
4. Is licensed by the state in which it operates.

Hospice care program means a coordinated, interdisciplinary program prescribed and supervised by a *physician* to meet the special physical, psychological, and social needs of a *terminally ill member* and those of his or her *immediate family.*

Hospital means an institution that:

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

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest,

custodial care or convalescent home, *rehabilitation facility*, *extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, a *member* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

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

Immediate family means the parents, *spouse*, children, or siblings of any *member*, or any person residing with a *member*.

Injury means accidental bodily damage sustained by a *member* that is the direct cause of the condition for which benefits are provided, independent of disease or body infirmity or any other cause that occurs while this *contract* is in force. All *injuries* due to the same accident are deemed to be one *injury*.

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

Intensive care unit means that part of a hospital service specifically designed as an *intensive care unit* permanently equipped and staffed to provide more extensive care for critically ill or injured patients than available in other hospital rooms or wards, the care to include close observation by trained and qualified personnel whose duties are primarily confined to the part of the hospital for which an additional charge is made.

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

Line therapist means an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment plan, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst.

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

Loss of minimum essential coverage means in the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), however this will not apply to a dependent living outside the service area if a court order requires the member to cover the dependent ;
3. In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
4. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in 26 CFR § 54.9802-1(d)) that includes the individual.
5. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.
6. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

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

Manipulative Therapy means treatment applied to the spine or joint structures to correct vertebral or joint malposition and to eliminate or alleviate somatic dysfunction including, but not limited to, manipulation, myofacial release or soft tissue mobilization. Treatment must demonstrate pain relief and continued improvement in range of motion and function and cannot be performed for maintenance care only. *Manipulative therapy* is not limited to treatment by manual means.

Maximum out-of-pocket amount is the sum of the *deductible amount*, *prescription drug deductible amount* (if applicable), *and copayment amount* and *coinsurance* percentage of *covered service expenses*, as shown in the *schedule of benefits*. After the *maximum out-of-pocket amount* is met for an individual, Ambetter from Home State Health pays 100% of *eligible expenses* for that individual. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket* amount. Both the individual and the family maximum out-of-pocket amounts are shown in the *schedule of benefits*.

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

If *you* are a covered *member* in a family of two or more *members*, *you* will satisfy *your* maximum out-of-pocket when:
1. *You* satisfy *your* individual *maximum out-of-pocket*; 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*, *you* will not pay any more *cost-sharing* for the remainder of the *calendar year*, but any other eligible *members* in *your* family must continue to pay *cost sharing* until the family *maximum out-of-pocket* is met for the *calendar year*.

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

Medical practitioner includes but is not limited to a *physician*, nurse anesthetist, *physician*'s assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *contract:* rolfer, hypnotist, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *member*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Medical care means the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body and for transportation primarily for and essential to the provision of such care.

Medically necessary means any medical service, supply or treatment authorized by a *physician* to diagnose and treat a *member's illness or injury* which:

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

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

Medically stabilized means that the person is no longer experiencing further deterioration as a result of a prior *injury* or *illness* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*.

Medicare participating practitioner means a *medical practitioner* who is eligible to receive reimbursement from Medicare for treating Medicare-eligible individuals.

Member or ***Covered Person*** means an individual covered by the health plan including an enrollee, subscriber or *policy* holder.

Mental disorder or ***Mental illness*** means those conditions classified as "mental disorders" in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, or the most recent edition of the International Classification of Diseases, Tenth Revision (ICD-10).
Necessary medical supplies mean medical supplies that are:

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

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

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

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

Network provider means a *physician* or provider who is identified in the most current list for the *network* shown on *your* identification card.

Non-elective caesarean section ***means:***

1. A caesarean section where vaginal delivery is not a medically viable option; or
2. A repeat caesarean section.

Non-Network Provider means a *physician* or provider who is NOT identified in the most current list for the *network* shown on *your* identification card. Services received from a *non-network provider* are not covered, except as specifically stated in this *policy*.

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

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

Outpatient services include facility, ancillary, and professional charges when given as an *Outpatient* at a Hospital, Alternative Care Facility, Retail Health Clinic, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and therapy services, surgery, or *rehabilitation*, or other Provider facility as determined by us. Professional charges only include services billed by a Physician or other professional.

Outpatient Contraceptive Services means consultations, examinations, and medical services, provided on an *outpatient* basis and related to the use of contraceptive methods to prevent *pregnancy* which has been approved by the U.S. Food and Drug Administration.

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

Period of extended loss means a period of consecutive days:

1. Beginning with the first day on which a *member* is a *hospital inpatient;* and
2. Ending with the 30th consecutive day for which he or she is not a *hospital inpatient.*

Pain management program means a program using interdisciplinary teams providing coordinated, goal- oriented services to a *member* who has chronic pain that significantly interferes with physical, psychosocial, and vocational functioning, for the purpose of reducing pain, improving function, and decreasing dependence on the health care system. A *pain management program* must be individualized and provide physical *rehabilitation*, education on pain, relaxation training, and medical evaluation.

Pharmacy care means medications used to address symptoms of an autism spectrum disorder prescribed by a licensed physician, and any health-related services deemed medically necessary to determine the need or effectiveness of the medications only to the extent that such medications are included in the insured's health benefit plan.

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

Post-service claim means any claim for a benefit under this contract that has already been provided.

Pre-service claim means any claim for benefits for medical care or treatment that has not yet been provided and requires the approval of the plan in advance of the member obtaining the medical care.

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

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

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

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

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

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

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

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

Psychiatric care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Psychological care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices

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

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

Rescission means a cancellation or discontinuance of coverage that has a retroactive effect. "Rescission" does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage

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

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

Rehabilitation facility means an institution or a separate identifiable *hospital* unit, section, or ward that:

1. Is licensed by the state as a *rehabilitation facility*; and
2. Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

Rehabilitation facility does not include a facility primarily for rest, the aged, long term care, assisted living, *custodial care,* nursing care*,* or for care of the mentally incompetent.

Rehabilitation medical practitioner means a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Rehabilitation therapy means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

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

Residence means the physical location where *you* live. If *you* live in more than one location, and *you* file a

United States income tax return, the physical address (not a P.O. Box) shown on *your* United States income tax return as *your* residence will be deemed to be *your* place of residence. If *you* do not file a United States income tax return, the *residence* where *you* spend the greatest amount of time will be deemed to be *your* place of *residence*.

Residential treatment facility means a facility that provides (with or without charge) sleeping accommodations, and:

1. Is not a *hospital, extended care facility,* or *rehabilitation facility;* or
2. Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

Retrospective review means utilization review of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Scalp Hair Prostheses means artificial substitutes for scalp hair that are made specifically for a specific *member*.

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

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

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

Specialist physician means a *physician* who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.
Spouse means the person to whom *you* are lawfully married.

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

Substance use disorder means alcohol, drug or chemical abuse, overuse, or dependency. Covered substance use disorders are those listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and the most recent edition of the International Classification of Diseases.
Surgery or ***surgical procedure*** means:

1. An invasive diagnostic procedure; or
2. The treatment of a member's illness or injury by manual or instrumental operations, performed by a *physician* while the *member* is under general or local anesthesia

Surveillance tests for ovarian cancer means annual screening using:

1. CA-125 serum tumor marker testing;
2. Transvaginal ultrasound; or
3. Pelvic examination.

Telehealth services means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management,

and self-management of a patient's health care while the patient is at the originating site and the provider for telehealth is at a distant site. Telehealth services includes synchronous interactions and asynchronous store and forward transfers.

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

Terminally ill means a *physician* has given a prognosis that a *member* has 12 months or less to live.

Therapeutic care means services provided by licensed speech therapists, occupational therapists, or physical therapists.

Third party means a person or other entity that is or may be obligated or liable to the *member* for payment of any of the *member's* expenses for *illness* or *injury*. The term *"third party"* includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. However, the term *"third party"* will not include any insurance company with a *policy* under which the *member* is entitled to benefits as a named *member* or an insured *dependent member* except in those jurisdictions where statutes or common law does not specifically prohibit *our* right to recover from these sources.

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

Treatment for autism spectrum disorders means care prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist, including equipment medically necessary for such care, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, including, but not limited to:

(a) Psychiatric care;
(b) Psychological care;
(c) Habilitative or rehabilitative care, including applied behavior analysis therapy;
(d) Therapeutic care;
(e) Pharmacy care.

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

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

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

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

Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the

clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, *care management*, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage.

DEPENDENT MEMBER COVERAGE

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

1. The date *you* became covered under this *contract;* or
2. The date of marriage to add a spouse; or
3. The date of a newborns birth; or
4. The date that an adopted child is placed with a *covered person* for the purposes of adoption or a *covered person* assumes total or partial financial support of the child.

Effective Date for Initial Dependents
The *effective date* for *your* initial *dependents,* if any, will be the same date as your initial coverage date.. Only *dependent members* included in the application for this *contract* will be covered on *your effective date*.

Coverage for a Newborn Child
An *eligible child* born to a *covered person* will be covered from the time of birth until the 31st day after its birth plus an additional 10 days.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth. If notice of the newborn is given to *us* by the Marketplace within the 31 days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 days after the birth of the child. If notice is given by the Marketplace within 60 days of the birth of the child, the *contract* may not deny coverage of the child due to failure to notify *us* of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st day after its birth, unless *we* have received notice from the entity that you have enrolled (either the Marketplace or us).

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

The child will be covered on the same basis as any other dependent.

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child and *we* have received notification from the Marketplace. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on the 31st day following *placement*, unless *we* have received both: (A) Notification of the addition of the child from the Marketplace within 60 days of the birth or placement and (B) any additional premium required for the addition of the child within 90 days of the date of *placement.*

As used in this provision, *"placement"* means the date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption pursuant to an adoption proceeding.
Adding Other Dependents

If *you* are enrolled in an off-Marketplace *policy* and apply in writing to add a *dependent* and *you* pay the required premiums, *we* will send *you* written confirmation of the added *dependent member's effective date* of coverage and ID Cards for the added dependent.

If a member is confined as an inpatient in a hospital on the effective date of this agreement, and prior coverage terminating immediately before the effective date of this agreement furnishes benefits for the hospitalization after the termination of prior coverage, then services and benefits will not be covered under this agreement for that

member until the member is discharged from the hospital or benefits under the prior coverage are exhausted, whichever is earlier.

ONGOING ELIGIBILITY

For All Members

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

1. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes;
2. The primary Member residing outside the Service Area or moving permanently outside the Service Area of this plan;
3. The date of a *member's* death;
4. The date that a *member* has failed to pay premiums or contributions in accordance with the terms of this *contract* or the date that we have not received timely premium payments in accordance with the terms of this *contract*;
5. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact; or

The date of termination that the Marketplace provides us upon your request of cancellation to the Marketplace, or if you enrolled directly with us, the date we receive a request from you to terminate this contract, or any later date stated in your request.

If you have material modifications (examples include a change in life event (marriage, death) or family status), or questions related to your health insurance coverage, contact the Health Insurance Marketplace at www.healthcare.gov or 1-800-318-2596. If you enrolled through Ambetter contact Member Services Department: 855-650-3789 TDD/TTY 877-250-6113

For Dependent Members

A *dependent member* will cease to be a *member* at the end of the premium period in which he or she ceases to be *your dependent member* due to divorce or if a child ceases to be an *eligible child*. For *eligible children*, coverage will terminate the thirty-first of December the year that the dependent turns 26 years of age. All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*.

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

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

Open Enrollment

There will be an open enrollment period for coverage on the Health Insurance Marketplace. The initial open enrollment period begins November 1, 2018 through December 15, 2018. *Qualified individuals* who enroll prior to December 15, 2018 will have an *effective date* of coverage on January 1, 2019.

Special Enrollment Period

A *Qualified individual* has 60 days to report a qualifying event to the Marketplace and could be granted a 60 day Special Enrollment Period as a result of one of the following events:

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

a. In the case of marriage, at least one spouse must demonstrate having minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage.

3. A *Qualified individual*, who was not previously a citizen, national, or lawfully present individual gains such status;
4. An individual who is no longer incarcerated or whose incarceration is pending the disposition of charges;
5. A *Qualified* individual's enrollment or non-enrollment in a *qualified* health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace or HHS, or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
6. An enrollee adequately demonstrates to the Health Insurance Marketplace that the *Qualified* health plan in which he or she is enrolled substantially violated a material provision of its *contract* in relation to the enrollee's decision to purchase the *qualified health plan* based on plan benefits, *service area* or premium;
7. An individual is determined newly eligible or newly ineligible for *Advanced Premium Tax Credit* or has a chance in eligibility for *cost-sharing reductions*, regardless of whether such individual is already enrolled in a *Qualified* health plan;
8. A *Qualified individual* gains access to new Qualified health plans as a result of a permanent move;
9. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
    a. The qualifying events for employees are:
        i. Voluntary or involuntary termination of employment for reasons other than gross misconduct; or
        ii. Reduction in the number of hours of employment.
    b. The qualifying events for *spouses* are:
        i. Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct;
        ii. Reduction in the hours worked by the covered employee;
        iii. Covered employee's becoming entitled to Medicare;
        iv. Divorce or legal separation of the covered employee; or
        v. Death of the covered employee.
    c. The qualifying events for dependent children are the same as for the *spouse* with one addition:
        i. Loss of dependent child status under the plan rules.
10. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified health plan or change from one Qualified health plan to another one time per month; or
11. A Qualified individual or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide.
12. A *qualified individual* or dependent is a victim of domestic abuse or spousal abandonment and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
13. A *qualified individual* or dependent is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 days after the qualifying event;
14. At the option of the Health Insurance Marketplace, a *qualified individual* provides satisfactory

documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a *qualified health plan* through the Health Insurance Marketplace following termination of Marketplace enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. §155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national or lawful presence.

In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance payments of the premium tax credit* and *cost-sharing reductions*, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where a *qualified individual* loses minimum essential coverage, the *effective date* is the first day of the following month.

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

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

PREMIUMS

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

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

We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period, and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. *We* will notify HHS of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the second and third month of the grace period. *We* will continue to collect advance premium tax credits on behalf of the *member* from the Department of the Treasury, and will return the advance premium tax credits on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above.

When a member is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a one (1) month grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *Contract* will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. *We* will notify HHS, as necessary, of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the grace period.

Third Party Payment of Premiums
Ambetter requires each policy holder to pay his or her premiums and this is communicated on *your* monthly billing statements. Ambetter payment policies were developed based on guidance from the Centers for Medicare and Medicaid Services (CMS) recommendations against accepting third party premiums. Consistent with CMS guidance, the following are the ONLY acceptable third parties who may pay Ambetter premiums on *your* behalf:

1. Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
2. Indian tribes, tribal organizations or urban Indian organizations;
3. State and Federal Government programs; or
4. Family members.

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

Reinstatement
If you have coverage purchased outside the Health Insurance Marketplace, and *your contract* lapses due to nonpayment of premium, it may be reinstated provided:

1. *We* receive from *you* a written application for reinstatement within one year after the date coverage lapsed; and
2. The written application for reinstatement is accompanied by the required premium payment.

Premium accepted for reinstatement may be applied to a period for which premium had not been paid. The period for which back premium may be required will not begin more than 60 days before the date of reinstatement.

The Rescissions provision will apply to statements made on the reinstatement application, based on the date of reinstatement. For coverage purchased via the Health Insurance Marketplace, the Health Insurance Marketplace should be contacted for reinstatement.

In all other respects, *you* and *we* will have the same rights as before *your contract* lapsed.

Misstatement of Age
If a Member's age has been misstated, the Member's premium may be adjusted to what it should have been based on the Member's actual age.

Change or Misstatement of Residence
If you change your residence, you must notify the Marketplace of your new residence within 60 days of the change. As a result your premium may change and you may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information.

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

Billing/Administrative Fees
Upon prior written notice, *we* may impose an administrative fee for credit card payments. This does not obligate *us* to accept credit card payments. *We* will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

COST SHARING FEATURES

Cost sharing Features
We will pay benefits for *Covered Service*s as described in the *schedule of benefits* and *the Covered Services* sections of this *Contract*. All benefits we pay will be subject to all conditions, limitations, and *cost sharing* features of this *Contract*. *Cost sharing* means that *you* participate or share in the cost of *your* healthcare services by paying *Deductible* amounts, *Copayments* and *Coinsurance* for some *Covered Services*. For example, *you* may need to pay a *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*.

Copayments
*Member*s may be required to pay *Copayments* at the time of services as shown in the *schedule of benefits*. Payment of a *Copayment* does not exclude the possibility of an additional billing if the service is determined to be a non-*covered service*. *Copayments* do not apply toward the *Deductible* amount, but do apply toward meeting the Maximum Out-of-Pocket amount.

Coinsurance Percentage
Members may be required to pay a *Coinsurance* Percentage in excess of any applicable *Deductible* amount(s) for a *Covered Service* or supply. *Coinsurance* amounts do not apply toward the *Deductible* but do apply toward meeting the Maximum Out-of-Pocket Amount. When the annual *out-of-pocket* maximum has been met, additional *covered service expenses* will be 100%.

Deductible
The *deductible amount* means the amount of *covered service expenses* that must be paid by all *members* before any benefits are payable. If on a family plan, if one *member* of the family meets his or her *deductible*, benefits for that *member* will be paid. The *deductible amoun*t does not include any *copayment amount* or *coinsurance* amount. Not all *covered service expenses* are subject to the *deductible* amount. See *your schedule of benefits* for more details.

Refer to *your schedule of benefits* for *Coinsurance* Percentage and Other Limitations
The amount payable will be subject to:

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

Note: The bill *you* receive for services or supplies from a *non-network provider* may be significantly higher than the *eligible expenses* for those services or supplies. In addition to the *deductible amount* and *coinsurance percentage*, *you* are responsible for the difference between the *eligible expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible expense* will not apply to *your deductible amount* or out-of-pocket maximum.

ACCESS TO CARE

Primary Care Provider
In order to obtain benefits, *you* must designate a *primary care provider* for each *member. You* may select any *network primary care provider* who is accepting new patients. However, *you* may not change *your* selection more frequently than once each month. If *you* do not select a *network primary care provider* for each *member,* one will be assigned. *You* may obtain a list of *network primary care providers* at *our* website or by contacting our *Member* Services department.

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

Network Availability
Your network is subject to change. The most current *network* may be found online at our website or by contacting *us* at the number shown on *your* identification card. A *network* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *contract* will no longer apply. In that event, benefits will be calculated based on the *eligible service expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

Coverage under Other Contract Provisions
Charges for services and supplies that qualify as *covered service expenses* under one benefit provision will not qualify as *covered service expenses* under any other benefit provision of this *contract.*

MEDICAL EXPENSE BENEFITS

The Plan provides coverage for healthcare services for a member and/or dependents. Some services require preauthorization.

Copayment amounts must be paid to your network provider at the time you receive services.

All Covered services are subject to conditions, exclusions, limitations, terms and provision of this policy. Covered service must be medically necessary and not experimental or investigational.

Benefit Limitations
Limitations may also apply to some covered services that fall under more than one Covered Service category. Please review all limits carefully. Ambetter from Home State Health will not pay benefits for any of the services, treatments, items or supplies that exceed benefit limits.

Ambulance Service Benefits
Covered service expenses will include ambulance services for local transportation:

1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.
3. Transportation between hospitals or between a hospital and skilled nursing or *rehabilitation* facility when *authorized* by Ambetter from Home State Health.

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.

Please note: if *you* receive services from *non-network ambulance providers*, you may be responsible for costs above the billed charges.

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. Non-*emergency* air ambulance.
3. Air ambulance:
    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. Ambulance services provided for a *member's* comfort or convenience.
5. Non-*emergency* transportation excluding ambulances (for example- transport van, taxi).

Autism Spectrum Disorder Expense Benefit
Covered service expenses for *autism spectrum disorder* include *coverage* for the diagnosis of *autism spectrum disorders* and for the *treatment of autism spectrum disorders*.

1. Upon request by *us*, a *provider* of treatment for *autism spectrum disorders* shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued

medical treatment is *medically necessary* and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, *we* may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

2. When making a determination of medical necessity for a treatment modality for *autism spectrum disorders*, *we* will make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under this *contract*, including an appeals process. During the appeals process, any challenge to *medical necessity* must be viewed as reasonable only if the review includes a *physician* with expertise in the most current and effective treatment modalities for *autism spectrum disorders*. Coverage for *medically necessary* early intervention services must be delivered by certified early intervention specialists.
    3. Habilitation and Rehabilitation services, for *member*s with a diagnosis of *autism spectrum disorder*, shall include: *applied behavior analysis* that is intended to develop, maintain, and restore the functioning of an individual. For physical therapy, speech therapy, or occupational therapy, there is no visit limit when used for the treatment of Autism Spectrum Disorders.

Clinical Trial Coverage

Clinical Trial Coverage includes routine patient care costs incurred as the result of an approved phase I, II, III or phase IV clinical trial and the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition. Coverage will include routine patient care costs incurred for (1) drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, (2) reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial and (3) all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

1. The investigational item or service itself:
2. 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
3. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

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 the insured is enrolled in the clinical trial. This section shall not apply to insured who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

Clinical trials can be approved if they are approved or funded by one of the following:

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. The FDA in the form of an investigational new drug application;
    7. The study or investigation is a drug trial that is exempt from having such 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. 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 for the purposes of prevention, early detection, or treatment of 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 serve the purposes of prevention, early detection, or treatment of 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 *us* upon request.

The coverage required by this section is subject to the standard *contract* provisions applicable to other benefits, including *deductible* and *coinsurance*.

Vision Expense Benefits

Routine Vision Adult 19 years of age and older

Routine eye exams, prescriptions eyeglasses, and initial supply of standard contact lenses are covered for all Ambetter from MHS plans and are managed through *your* vision vendor. For information regarding *your* specific copayments or *deductible amounts* please refer to *your* specific plan information listed in the *Schedule of Benefits*. *You* may receive one routine eye exam and eyewear once every calendar year. Eyewear includes either one pair of eyeglasses or initial supply of standard contacts.

- **Eyeglasses**

Covered lenses include single vision, lined bifocal, lined trifocal, or lenticular in glass or plastic. Covered lens add-ons include standard polycarbonate lenses, scratch resistant and anti-reflective coating. If *you* require a more complex prescription lens, contact *your* vision vendor for *prior authorization*. Lens options such as progressive lenses, high index tints and UV coating are not covered.

For *your* maximum allowance for eyeglass frames please refer to *your* specific plan information listed in the *Schedule of Benefits*. Covered frames are to be selected from *your* vision vendor's frame formulary, offering a wide range of frames that are at no cost to you.

Should *you* choose to select a frame that is more than *your* maximum benefit, *you* will be financially responsible for the difference.

- **Contact Lenses**

Coverage includes evaluation, fitting, and initial supply of standard contact lenses. Please refer to *your* specific plan information listed in the *Schedule of Benefits* for *your* maximum allowance for contacts.

For additional information about covered vision services, participating vision vendor providers, call Member Services at 1-855-650-3789.

Dental Benefits – Adults 19 years of age or older

Coverage is provided for adults, age 19 and older, for Preventative and Diagnostic (Basic)—Class 1, and Basic Restorative (Comprehensive)—Class 2 dental services from an *In-Network provider*.

1. Preventative and Diagnostic (Basic)—Class 1 benefits include:
    a. Routine Cleanings;
    b. Oral Exams;
    c. X-rays – bite-wing, full-mouth and panoramic film;
    d. Topical fluoride application;
    e. Palliative Treatment for emergency relief of pain.
2. Minor Restorative (Comprehensive)— Class 2 benefits include:
    a. Minor Restorative – metal and resin based filings;
    b. Endodontics – therapeutic pulpotomy and pulp cap;
    c. Periodontics – scaling, root planning and periodontal maintenance;
    d. Oral Surgery and Extractions
    e. Prosthodontics – relines, rebase, adjustment and repairs.

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

Services not covered for adult Preventative and Diagnostic (Basic)—Class 1, and Minor Restorative (Comprehensive)—Class 2 benefits include:

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

21. Splinting;
22. Temporal Mandibular Joint disorder (TMJ) appliances, therapy, films and arthorograms;
23. Lab tests including, but not limited to viral culture, saliva diagnostics, caries testing;
24. Consultations by the treating provider and office visits;
25. Initial installation of implants, full or partial dentures or fixed bridgework to replace a tooth or teeth extracted prior to the *member*'s *effective date*;
26. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
27. Veneers (bonding of coverings to the teeth);
28. Orthodontic treatment procedures;
29. Corrections to congenital conditions, other than for congenital missing teeth;
30. Athletic mouth guards;
31. Retreatment or additional treatment necessary to correct or relieve the results of previous treatment;
32. Space maintainers for anyone 19 years of age or older.

Other Dental Services

Anesthesia and *hospital* charges for dental care, for a *member* less than 19 years of age or a *member* who is physically or mentally disabled, are covered if the *member* requires dental treatment to be given in a *hospital* or outpatient ambulatory surgical facility. The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the *member's* condition under general anesthesia.

Coverage is also provided for:

1. For Medically Necessary oral surgery, including 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 jaw bone and is medically necessary to attain functional capacity of the affected part.
    c. Oral / surgical correction of accidental injuries as indicated in the "Dental Services" section.
    d. Surgical services as described in the "Temporomandibular Joint (TMJ) and Craniomandibular Joint Services" section.
    e. Treatment of non-dental lesions, such as removal of tumors and biopsies.
    f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
    g. Surgical procedures that are Medically Necessary to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.
    h. Reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, *illness*, *injury* or an earlier treatment in order to create a more normal appearance. Benefits include *surgery* performed to restore symmetry after a mastectomy.
2. Dental anesthesia charges include coverage for the administration of general anesthesia and hospital or office charges for dental care, rendered by a dentist, provided to the following *members*:
    a. a child under the age of five;
    b. a person who is severely disabled; or
    c. a person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.
3. For *dental service expenses* when a *member* suffers an *injury,* that results in:
    a. Damage to his or her natural teeth;
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within 12 months of the accident to be considered as a covered service; and

c. *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, malocclusions, or disorders of the temporomandibular joint

Diabetic Care
Benefits are available for *medically necessary* services and supplies used in the treatment of diabetes.

Covered service expenses include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies, glucose strips for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication;

Dialysis Services
We cover medically necessary acute and chronic dialysis services.

Covered expenses include:
- Services provided in an Outpatient Dialysis Facility or when services are provided in the Home;
- Processing and administration of blood or blood components;
- Dialysis services provided in a Hospital;
- Dialysis treatment of an acute or chronic kidney ailment which may include the supportive use an artificial kidney machine.

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

Durable Medical Equipment, Prosthetics, and Orthotic Devices
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 allowable amount for a standard item that is a covered service, serves the same purpose, and is *medically necessary*. Any expense that exceeds the maximum allowable amount for the standard item which is a covered service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition. Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

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

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

1. The equipment, supply or appliance is worn out or no longer functions.

2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by the *habilitation* equipment specialist or 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. Augmentive communication devices are covered when we approve based on the *member's* condition.

Exclusions:

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

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

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 benefits).
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 Artificial 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 (the first one following cancer treatment, not to exceed one per benefit period).

Exclusions:
Non-covered prosthetic appliances include but are not limited to:
1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Artificial heart implants.
5. Wigs (except as described above following cancer treatment).
6. Penile prosthesis in *members* suffering impotency resulting from disease or injury.

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 appliance 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.

Orthotic appliances may be replaced once per year per Member when *medically necessary* in the *member's* situation. However, additional replacements will be allowed for *members* under age 18 due to rapid growth, or for any *member* when an appliance is damaged and cannot be repaired.

Exclusions:
Non-covered services include but are not limited to:
1. Orthopedic shoes (except therapeutic shoes for diabetics).
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under medical supplies).
4. Garter belts or similar devices.

Habilitation, Rehabilitation and Extended Care Facility Expense Benefits
Covered service expenses include expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:
1. *Covered service expenses* available to a *member* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision;

2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay;
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
    a. Daily room and board and nursing services;
    b. Diagnostic testing; and
    c. Drugs and medicines that are prescribed by a *physician*, filled by a licensed pharmacist, and approved by the U.S. Food and Drug Administration;
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioners.*
5. Coverage for a Skilled Nursing Facility and inpatient rehabilitation is limited to 150 days per year.
6. *Habilitation* Services are limited to 20 visits per year for Occupational Therapy and Physical Therapy. There is not a visit limit for Speech Therapy or Autism Services.
7. *Rehabilitation* Services are limited to 20 visits per year for Occupational Therapy and Physical Therapy. There is not a visit limit for Speech Therapy or Autism services.
8. Coverage for Cardiac *Rehabilitation*.

See the *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*.

Definition:
As used in this provision, *"provider facility"* means a *hospital, rehabilitation facility*, or *extended care facility*.

Home Health Care Service Expense Benefits
Covered service expenses for *home health care* 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;*
3. Services of a private duty registered nurse rendered on an outpatient basis. Please refer to your Schedule of Benefits for any limits associated with this benefit.
4. I.V. medication and pain medication;
5. Hemodialysis, and for the processing and administration of blood or blood components;
6. *Medically necessary medical supplies*;
7. Rental of *medically necessary durable medical equipment;* and
8. Sleep studies.

I.V. medication and pain medication are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient* hospital stay.

At *our* option, *we* may *authorize* the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we authorize* before the purchase. If the equipment is purchased, the *member* must return the equipment to *us* when it is no longer in use.

Limitations:
See the *schedule of benefits* for benefit levels or additional limits for expenses related to home health aide services.

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

Hospice Care Service Expense Benefits
This provision only applies to a *terminally ill member* receiving *medically necessary* care under a *hospice care program*. *Covered services* include:

The list of *covered service expenses* in the Miscellaneous Medical Service Expense Benefits provision is expanded to include:

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

Benefits for *hospice inpatient,* home or *outpatient* care are available to a *terminally ill member* for one continuous period up to 365 days per benefit period. 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 *contract* regarding:

1. An *injury* or *illness* arising out of, or in the course of, employment for wage or profit;
2. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice care program;* or
3. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision.

Respite Care Expense Benefits
Respite care is covered on an *inpatient or outpatient basis to allow* temporary relief to family members from the duties of caring for a *member* who is undergoing *hospice* care. Respite days that are applied toward the *deductible amount* are considered benefits provided and shall apply against any Maximum Benefit limit for these services.

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

1. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
2. A private hospital room when needed for isolation.
3. Daily room and board and nursing services while confined in an *intensive care unit*.

4. *Inpatient* use of an operating, treatment, or recovery room.
5. *Outpatient* use of an operating, treatment, or recovery room for *surgery.*
6. Services and supplies, including drugs and medicines, which are routinely provided by the *hospital* for use only while *you* are *inpatient.*
7. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. See *your schedule of benefits* for limitations.

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

Mammography Coverage
Typical breast cancer screening mammography, which includes the following:
1. If the *member* is at least thirty-five (35) years of age but less than forty (40) years of age, coverage for at least one (1) baseline breast cancer screening mammography performed upon *member* before they become forty (40) years of age; or
2. If the *member* is less than forty (40) years of age and at risk, one (1) typical breast cancer screening mammography performed upon the *member* every year; or
3. If the enrollee is at least forty (40) years of age, one (1) typical breast cancer screening mammography performed upon the *member* every year; and
4. Any additional mammography views that are required for proper evaluation; and
5. Ultrasound services, if determined *medically necessary* by the *physician* treating the *member*.

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.

Our behavioral health and substance use vendor oversees the delivery and oversight of covered behavioral health and substance use disorder services for Home State Health. Mental health services will be provided on an *inpatient* and *outpatient* basis and include treatable mental disorders. These disorders affect the *member*'s ability to cope with the requirements of daily living. If *you* need mental health and/or substance use disorder treatment, *you* may choose any provider participating in *our* behavioral health and substance use vendor's provider network. *Deductible amounts*, *copayment* or *coinsurance* amounts and treatment limits for covered mental health and substance use disorder benefits will be applied in the same manner as physical health service benefits.

Covered services for mental health and substance use disorder are included on a non-discriminatory basis for all *Member*s for the diagnosis and treatment of mental, emotional, and/or substance use disorders, including *pervasive developmental disorders* as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association and the most current version of the International Statistical Classification of Diseases and Related Health Problems (ICD). Treatment is limited to services prescribed by *your Physician* in accordance with a treatment plan.

When making coverage determinations, *our* behavioral health and substance use vendor utilizes 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 and substance use vendor utilizes "Interqual" criteria for mental health determinations and ASAM American Society of Addiction Medicine (ASAM) criteria for *substance use* determinations. Services should always

be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

Covered *Inpatient*, and *Outpatient* mental health and/or substance use disorder services are as follows:

Inpatient

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

Outpatient

1. Partial Hospitalization Program (PHP)
2. Intensive *Outpatient* Program (IOP);
3. *Outpatient* detoxification programs;
4. Evaluation and assessment for mental health and substance use, at least 2 sessions per year. These sessions may be with an out-of-network provider;
5. Individual and group therapy for mental health and substance use;
6. Medication Assisted Treatment- combines behavioral therapy and medications to treat substance use disorders;
7. Medication management services;
8. Psychological and Neuropsychological testing and assessment;
9. Applied Behavioral Analysis for treatment of autism;
10. Mental Health day treatment
11. Telehealth*;* and
12. Electroconvulsive Therapy (ECT).

Behavioral health covered services are only for the diagnosis or treatment of mental health conditions and the treatment of substance use/chemical dependency.

Expenses for these services are covered, if *medically necessary* and may be subject to prior *authorization*. Please see the s*chedule of benefits* for more information regarding services that require prior *authorization* and specific benefit, day or visit limits, if any.

Medical Foods

We cover medical foods and formulas when medically necessary for the treatment of Phenylketonuria (PKU).

Chiropractic Services

We cover charges for chiropractic services. These services will be covered for a *member* who presents a condition of an orthopedic or neurological nature necessitating treatment for which falls within the scope of a licensed chiropractor.

Medical and Surgical Expense Benefits

Medical *covered service expenses* are limited to charges:

5. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies.
6. For services received for urgent care, including facility charges at an urgent care center.

7. Made by a *physician* for professional services, including *surgery.*
8. Made by an assistant surgeon.
9. For dressings, crutches, orthopedic splints, braces, casts, or other *medically necessary medical supplies.*
10. For diagnostic testing using radiologic, ultrasonographic, or laboratory services.
11. For chemotherapy and radiation therapy or treatment.
12. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
13. For the cost and administration of an anesthetic.
14. For oxygen and its administration.
15. For *dental service expenses* when a *member* suffers an *injury,* that results in:
    a. Damage to his or her natural teeth;
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within 12 months of the accident to be considered as a covered service; and
    c. *Injury* to the natural teeth will not include any injury as a result of chewing.
16. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint
17. 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 lymphedemas.
18. For Chiropractic Care, including office visits for assessment, evaluation, spinal adjustment, *medically necessary manipulative therapy* treatment on an *outpatient* basis and physiological therapy before (or in conjunction with) spinal adjustment up to 26 visits per benefit period; visits in excess of 26 will require *prior authorization*
19. For pulse oximetry screening on a newborn.
20. Well Child care examinations for children through the age of 12, including child health supervision services, based on American Academy of Pediatric Guidelines. Refer to Preventive Services for a list of well child/well baby services.
21. For medically necessary human organ and tissue transplants.
22. 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.
23. For treatment received outside the United States *while* traveling for up to a maximum of (90) consecutive days.
24. Newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.
25. Allergy testing, injections and serum.
26. For the provision of nonprescription enteral formulas and food products required for *members* with inherited diseases of amino acids and organic acids. 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. 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;
27. For scalp hair prosthesis expenses for hair loss suffered as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia, or permanent loss of scalp hair due to injury. Such coverage, shall be subject to a written recommendation by the treating *physician* stating that the hair prosthesis is a medical necessity;
28. 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;

29. For medically necessary diagnostic and laboratory and x-ray tests;
30. Cost for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. Coverage is limited to a maximum cost of $75.
31. 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*:
    a. a child under the age of five;
    b. a person who is severely disabled; or
    c. a person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.
32. 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.
33. For cancer screenings, as follows:
    a. A pelvic examination and pap smear for any nonsymptomatic woman who is a *member*, in accordance with the current American Cancer Society guidelines;
    b. A prostate examination and laboratory tests for cancer for any nonsymptomatic man who is a *member*, in accordance with the current American Cancer Society guidelines; and
    c. A colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic *member*, in accordance with the current American Cancer Society guidelines.
34. For telehealth for *covered service*s provided within the scope of practice of a physician or other healthcare provider as a method of delivery of medical care by which a member shall receive medical services from a healthcare provider without in-person contact with the provider;
35. 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 jaw bone and is medically necessary to attain functional capacity of the affected part.
    c. Oral / surgical correction of accidental injuries as indicated in the "Dental Services" section.
    d. Surgical services as described in the "Temporomandibular Joint (TMJ) and Craniomandibular Joint Services" section.
    e. Treatment of non-dental lesions, such as removal of tumors and biopsies.
    f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
    g. Surgical procedures that are Medically Necessary to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.
    h. Reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, *illness*, *injury* or an earlier treatment in order to create a more normal appearance. Benefits include *surgery* performed to restore symmetry after a mastectomy.
36. For respiratory and pulmonary therapy;
37. For *medically necessary* genetic blood tests; and
38. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV).

Outpatient Medical Supplies Expense Benefits

Covered service expenses for miscellaneous *outpatient* medical services and supplies are limited to charges:

1. For artificial eyes or 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 *covered person's* functional needs, only the charge for the most cost effective prosthetic device will be considered a *covered service expense*.

2. For one pair of foot orthotics per *member*.
3. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.
4. For the cost of one Continuous Passive Motion (CPM) machine per *member* following a covered joint surgery.
5.
6. Infusion therapy.
7. For one pair of eyeglasses or contact lenses per *member* following a covered cataract surgery.
8. Services related to diagnosis, treatment and appropriate management of osteoporosis when such services are provided by a person licensed to practice medicine and surgery in the state, if the *member* has a condition or medical history for which bone mass measurement is medically indicated.
9. Testing of pregnant women and other *members* for lead poisoning.
10. For any other use of a drug approved by the United States Food and Drug Administration when the drug has not been approved by the United States Food and Drug Administration for the treatment of the particular indication for which the drug has been prescribed, provided such drug is recognized for treatment of such indication in one of the standard reference compendia or in the medical literature as recommended by current American Medical Association (AMA) policies. Any coverage of a drug required shall also include medically necessary services associated with the administration of the drug. This benefit shall not be construed to require:
    a. Coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;
    b. Coverage for experimental or investigational drugs not approved for any indication by the FDA; and
    c. Reimbursement or coverage for any drug not included on the drug formulary or list of covered drugs specified in this *contract*.

Maternity Care

An inpatient stay is covered for mother and newborn for a minimum of 48 hours following a vaginal delivery and 96 hours following a delivery by cesarean section. We do not require that a physician or other healthcare provider obtain prior authorization. An inpatient stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require prior authorization.

Other maternity benefits which may require prior authorization include:

a. Outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, and childbirth classes.
b. Physician Home Visits and Office Services.
c. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
d. Complications of pregnancy.
e. Hospital stays for other medically necessary reasons associated with maternity care.

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

(1) give birth in a hospital or other healthcare facility; or
(2) remain under inpatient care in a hospital or other healthcare facility for any fixed term following the birth of a child.

Maternity coverage of a home birth by a midwife or nurse midwife is limited to low risk Pregnancy and may be

subject to *preauthorization* requirements.

Newborns' and Mothers' Health Protection Act Statement of Rights
If expenses for *hospital* confinement in connection with childbirth are otherwise included as *covered service expenses*, *we* will not limit the number of days for these expenses to less than that stated in this provision.

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

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 *contract* to restrict any terms, limits, or conditions that may otherwise apply to *covered service expenses* for childbirth.

Prescription Drug Expense Benefits
Covered service expenses in this benefit subsection are limited to charges from a licensed *pharmacy* for:

1. A *prescription drug;*
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a physician;
3. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one (1) standard reference compendium; or
    b. Recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain; and
4. Prescribed, oral anticancer medication;
5. Self-administered human growth hormones to treat persons with short stature who have an absolute deficiency in natural growth hormone. Benefits are also available to treat persons with short stature who have chronic renal insufficiency and who do not have a functioning renal transplant.

See the *schedule of benefits* for benefit levels or additional limits.

Covered prescription drugs, which are not subject to utilization management, *prior authorization*, or pre-certification requirements, and are considered maintenance, are covered up-to-90-day supply at retail pharmacies within our network. Controlled substances as identified by the United States Drug Enforcement Administration are exempt from this section. The prescription drugs received in a 90-day supply may be subject to co-payments, *coinsurance deductible*s, or other member cost shares.

The appropriate drug choice for a *member* is a determination that is best made by the *member* and his or her *physician.* If *we* change our formulary we will provide *you* with notification of the change at least thirty (30) days in advance of the change.

Notice and Proof of Loss:
In order to obtain payment for *covered service expenses* incurred at a *pharmacy* for *prescription orders,* a

notice of claim and *proof of loss* must be submitted directly to *us.*

Non-Covered Services and Exclusions:
No benefits will be paid under this benefit subsection for services provided or 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 by the Affordable Care Act
3. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals;
4. For a refill dispensed more than 12 months from the date of a *physician's* order.
5. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
6. 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 covered on the formulary, or when the over-the-counter drug is used for preventive care.
7. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
8. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program;
9. For more than a 34-day supply when dispensed in any one prescription or refill (a 90-day supply when dispensed by mail order).
10. In excess of the cost of the generic equivalent, if any, regardless of whether the *physician* specifies name brand on the written prescription.
11. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.
12. Off-label use, except as required by law or as expressly approved by us;
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. Drugs or dosage amounts determined by Ambetter 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;
15. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations;
16. Medications used for cosmetic purposes; or
17. 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.

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.
Standard exception request

A *member*, a *member's* designee 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* designee 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.

Expedited exception request

A *member*, a *member's* designee 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 enrollee's life, health, or ability to regain maximum function or when an enrollee 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* designee or the *member's* prescribing *physician* with *our* coverage determination. Should the standard 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* designee or the *member's* prescribing *physician* may request that the original exception request and subsequent denial of such request be reviewed by an external review organization. *We* will make *our* determination on the external exception request and notify the *member*, the *member's* designee 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.

Cost sharing paid on your behalf for any prescription drugs obtained by you through the use of a drug discount, coupon, or copay card provided by a prescription drug manufacturer will not apply toward your plan deductible or your maximum out of pocket.

Pediatric Vision Expense Benefits

Covered service expenses in this benefit subsection include the following for an *eligible child* under the age of 19 who is a *member*:

1. Routine vision screening, including dilation and with refraction every *calendar year*;
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal or lenticular) or initial supply of contacts every *calendar year*, including standard polycarbonate lenses, scratch resistant and anti- reflective coating;
3. One pair of frames every *calendar year*.
4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when *pre-authorized.*
5. UV coating.
6. Photochromic lenses.
7. Non-Elective Contact Lenses – Only for the following medical conditions:
    a) Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
    b) High Ametropia exceeding -12D or +9D in spherical equivalent.
    c) Anisometropia of 3D or more.
    d) When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Covered service expenses do not include:

1. Visual therapy;
2. Two pair of glasses as a substitute for bifocals;
3. Replacement of lost or stolen eyewear;
4. Any vision services, treatment or material not specifically listed as a *covered service*; or
5. Out of network care, except when *pre-authorized*.

Preventive Care Expense Benefits

Covered service expenses are expanded to include the charges incurred by a *member* for the following preventive health services if appropriate for that *member* in accordance with the following recommendations and guidelines:

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. Examples of these services are screenings for cervical cancer and mammography.
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual.
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.
4. Additional preventive care and screenings not included above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.
5. All FDA-approved contraception methods (identified on www.fda.gov) are approved for *member*s without *cost sharing* as required under the Affordable Care Act. *Member*s have access to the methods available and outlined on our Drug Formulary or Preferred Drug List 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*; and
6. Covers without *cost sharing*:
    a. Screening for *tobacco use*; and
    b. For those who *use tobacco* products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
        i. Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior *authorization*; and
        ii. All Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a healthcare provider without prior *authorization*.

Benefits for preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any *deductible amounts, cost sharing percentage* provisions, and *copayment amounts* under the *contract* when the services are provided by a *network provider.*

Benefits for *covered service expenses* for preventive care expense and chronic disease management benefits may include the use of reasonable medical management techniques *authorized* by federal law to promote the use of high value preventive services from *network providers*. Reasonable medical management techniques may result in the application of *deductible amounts*, *coinsurance* provisions, or *copayment amounts* to services when a *member* chooses not to use a high value service that is otherwise exempt from *deductible amounts*, *coinsurance* provisions, and *copayment amounts*, when received from a *network provider*.

As new recommendations and guidelines are issued, those services will be considered *covered service*

expenses when required by the United States Secretary of Health and Human Services, but not later than one year after the recommendation or guideline is issued.

Notification
As required by section 2715(d)(4) of the Public Health Service Act, we will provide 60 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 at 1-855-650-3789 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.homestatehealth.com.

You may also access the Federal Government's website at www.healthcare.gov/center/regulations/prevention.html to obtain current information.

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

If a service is considered diagnostic or non-preventive care, your "plan" copayment, coinsurance and deductible will apply. It's important to know what type of service you're getting. If a diagnostic or non-preventive service is performed during the same healthcare visit as a preventive service, you may have copayment and coinsurance charges. If a member and/or dependents receive any other covered services during a preventive care visit, the member may be responsible to pay the applicable Copayment and Coinsurance for those Services.

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

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

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

Transplant Expense Benefits
If *we* determine that a *member* is an appropriate candidate for a *medically necessary* transplant, benefits will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting.
3. Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *member* to prepare for a later transplant, whether or not the transplant occurs.
4. High dose chemotherapy.
5. Peripheral stem cell collection.

6. The transplant itself, not including the acquisition cost for the organ or bone marrow (except at a *Center of Excellence*).
7. Post-transplant follow-up.
8. Transportation for the *member*, any live donor, and the *immediate family* to accompany the *member* to and from the facility where the transplant will be performed.
9. Lodging for the *member*, any live donor and the immediate family accompanying the *member* while the *member* is confined. We will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Transplant Donor Expenses:
We will cover the medical expenses incurred by a live donor as if they were medical expenses of the *member* if:

1. They would otherwise be considered *covered service expenses* under the *contract;*
2. The *member* received an organ or bone marrow of the live donor; and
3. The transplant was a *medically necessary transplant.*

Ancillary "*Center Of Excellence*" Service Benefits:
A *member* may obtain services in connection with a *medically necessary transplant* from any *physician*. However, if a *medically necessary transplant* is performed in a *Center of Excellence, covered service expenses* for the *medically necessary transplant* will include the acquisition cost of the organ or bone marrow.

Non-Covered Services and Exclusions:
No benefits will be provided or paid under these Transplant 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 artificial or mechanical devices designed to replace a human organ temporarily or permanently.
4. Left Ventricular Artificial Devices (LVAD) when used as destination;
5. Total artificial heart is not covered (even though it is a bridge to transplant);
6. To keep a donor alive for the transplant operation.
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
8. Related to transplants not included under this provision as a *medically necessary* transplant.

Food and Drug Administration (FDA) regulation, regardless of whether the trial is subject to FDA oversight. For a *medically necessary* transplant under study in an ongoing phase I or II clinical trial as set forth in the United States

Health Management Programs Offered

Ambetter from x offers the following health management programs:
1. Asthma;
2. Coronary Artery Disease;
3. Diabetes (adult and pediatric);
4. Hypertension;
5. Hyperlipidemia;
6. Low Back Pain; and
7. Tobacco Cessation.

To inquire about these programs or other programs available, you may visit our website at ambetter.homestatehealth.com or by contacting Member Services at 855-650-3789.

UTILIZATION REVIEW (AUTHORIZATION)

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

For services or supplies that require *prior authorization*, as shown on the *schedule of benefits*, *you* must obtain *authorization* from *us* before the *member:*

1. Receives a service or supply from a non-*network provider;*
2. Is admitted into a *network* facility by a non-*network provider;* or
3. Receives a service or supply from a *network provider* to which the *member* was referred by a non-*network provider.*

Prior Authorization must be obtained for the following services, except for Urgent Care or Emergency Services. This list is not exhaustive, to confirm if a specific service requires Prior Authorization, please contact Member Services.

a. Non-Emergency Health Care Services provided by Non-Network Providers;
b. Reconstructive procedures;
c. Diagnostic Tests such as specialized labs, procedures and high technology imaging;
d. Injectable drugs and medications;
e. Inpatient Health Care Services;
f. Specific surgical procedures;
g. Nutritional supplements;
h. Pain management services; and

Transplant services.
Prior Authorization requests can be submitted by telephone, eFax, or provider web portal. Although not required, submitting requests within the recommended timeframes below will allow for timely review of prior authorization requests.

1. At least 5 days prior to an elective admission as an *inpatient* in a hospital, extended care or *rehabilitation* facility, or hospice facility.
2. At least 30 days prior to the initial evaluation for organ transplant services.
3. At least 30 days prior to receiving clinical trial services.
4. Within 24 hours of any inpatient admission, including emergent inpatient admissions.
5. At least 5 days prior to the start of home healthcare except those members needing home health care after hospital discharge.

After prior *authorization* has been requested and all necessary information, including the results of any face-to-face clinical evaluation or second opinion that may be required has been submitted, we will notify *you* and *your* provider if the request has been approved as follows:

1. For immediate request situations, within 24 hours, when the lack of treatment may result in an *emergency* room visit or *emergency* admission.
2. For non-urgent pre-service requests regarding proposed admission, procedure or service within 36 hours which shall include one working day of obtaining all necessary information regarding the request.
3. For post-service requests, with in 30 calendar days of receipt of the request.

Except for *medical emergencies*, prior *authorization* must be obtained before services are rendered or expenses are *incurred*.

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

Failure to Obtain Prior Authorization
Network providers cannot bill *you* for services for which they fail to obtain *prior authorization* as required. In cases of emergency, benefits will not be reduced for failure to comply with *prior authorization* requirements*.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

Prior Authorization Does Not Guarantee Benefits
Our authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *contract.*

Payment for authorized services may be denied, and an authorization may be rescinded, if:
1. Such authorization is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition; or
2. The health benefit plan terminates before the health care services are provided; or
3. The covered person's coverage under the health benefit plan terminates before the health care services are provided.

If all terms and conditions of the contract are met and *we* authorize a proposed admission, treatment, or *covered service* expense by a *network provider* based upon the complete and accurate submission of all necessary information relative to an eligible member, *we* shall not retroactively deny this authorization if the *network provider* renders the *covered service* expense in good faith and pursuant to the authorization and all of the terms and conditions of the *network provider's* contract with us.

Requests for Predeterminations
You may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:
1. The predetermination was based on incomplete or inaccurate information initially received by *us.*
2. The medical expense has already been paid by someone else.

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

Notice of Prior Authorization
A Notice of *Prior Authorization* includes:
1. The number of certified days of hospital confinement;
2. The medical diagnosis, and if applicable, the surgical procedure that was certified;

3. Instructions for a physician to request additional days of hospital confinement (if necessary); and
4. Instructions regarding questions about the *authorization* process.

Notice of Adverse Determination
If treatment is not medically appropriate and medically necessary, the provider will be informed of the adverse determination by telephone within twenty-four hours of making the adverse determination, and written or electronic confirmation of the telephone notification will be provided to the member and the provider within one working day of making the adverse determination.

If a member decides to receive non-certified medical treatment, then no benefits are paid. The member may elect to file an Appeal with us. At all times, the final decision for actual medical treatment to be provided is the right and responsibility of the member and the physician.

Concurrent Review Determinations
For concurrent review determinations, a determination will be made within 24 hours of obtaining all necessary information. In the case of a determination to certify an extended stay or additional services, the *provider* rendering the service will be notified by telephone within one working day of making the *authorization*, and written or electronic confirmation of the telephone notification will be provided to the *member* and the *provider* within one working day after the telephone notification. The notification will include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

In the case of an adverse determination, the *provider* rendering the service will be notified by telephone within twenty-four hours of making the *authorization*, and written or electronic confirmation of the telephone notification will be provided to the *member* and the *provider* within one working day after the telephone notification. In any case, services will be continued without liability to the *member* until the *member* has been notified of a determination.

Concurrent Care Decisions
Reduction or termination of ongoing plan of treatment
If we have approved an ongoing plan or course of treatment that will continue over a period of time or a certain number of treatments and we notify you that we have decided to reduce or terminate the treatment, we will give you notice of that decision allowing sufficient time to appeal the determination and to receive a decision from us before any interruption of care occurs.

Request to extend ongoing treatment
If you have received approval for an ongoing treatment and wish to extend the treatment beyond what has already been approved, we will consider your appeal as a request for urgent care. If you request an extension of treatment at least 24 hours before the end of the treatment period, we must notify you soon as possible but no later than 24 hours after receipt of the claim. An appeal of this decision is conducted according to the urgent care appeals procedures.

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

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

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

Retrospective Review Determinations
For retrospective review determinations, a determination will be made within thirty working days of receiving all necessary information. A written notice of the determination will be provided to the *member* within ten working days of making the determination.

Reconsideration of Determination
In a case involving an initial determination or a concurrent review determination, the *provider* rendering the service may request on behalf of the *member* a reconsideration of an adverse determination by the reviewer making the adverse determination. The reconsideration will occur within one working day of the receipt of the request and will be conducted between the *provider* rendering the service and the reviewer who made the adverse determination or a clinical peer designated by the reviewer if the reviewer who made the adverse determination is not available within one working day. If the reconsideration process does not resolve the difference of opinion, the adverse determination may be appealed by the *member* or the *provider* on behalf of the *member*. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an adverse determination.

Notification
It is *your* responsibility to notify *us* and arrange for the release of necessary medical information from *your physician* to the Utilization Review Organization. *You* may also arrange for the *hospital* or *your physician* to notify the Utilization Review Organization; however, if for any reason *your physician* or *hospital* fails to cooperate, the penalty applies as described in the Failure to Obtain *Prior Authorization* provision of this section.

Notification is required for all *hospital confinements*, *psychiatric care*, *outpatient surgeries*, *major diagnostic tests*, *home health care*, *extended care facility* confinements, *hospice services, rehabilitation facility* confinements, *skilled nursing facilities* and *transplants*. Notification MUST take place at least two weeks prior to the scheduled confinement, treatment or service.

Services from Non- Network Providers
Except for emergency medical services, we do not normally cover services received from *non-network providers*. If a situation arises where a *covered service* cannot be obtained from a *network provider* located within a reasonable distance, we may provide a prior authorization for you to obtain the service from a *non-network provider* at no greater cost to you than if you went to a *network provider*. If *covered services* are not available from a *network provider*, you or your *primary care provider* must request *prior authorization* from us before you receive services from a *non-network provider*. Otherwise, you will be responsible for all charges incurred.

HOSPITAL BASED PROVIDERS
When receiving care at an Ambetter participating *hospital* it is possible that some *hospital*-based providers (for example, anesthesiologists, radiologists, pathologists) may not be under contract with

Ambetter as participating providers. These providers may bill *you* for the difference between Ambetter's allowed amount and the providers billed charge – this is known as "*balance billing*". *We* encourage *you* to inquire about the providers who will be treating *you* before *you* begin *your* treatment, so *you* can understand their participation status with Ambetter.

Although healthcare services may be or have been provided to *you* at a healthcare facility that is a *member* of the provider network used by Ambetter, other professional services may be or have been provided at or through the facility by physicians and other medical practitioners who are not *member*s of that network. *You* may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by Ambetter.

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *member* in the absence of insurance covering the charge.
2. Expenses/surcharges imposed on the *member* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.
3. Any services performed by a member of a *member's immediate family.*
4. Any services not identified and included as *covered service expenses* under the *contract*. *You* will be fully responsible for payment for any services that are not *covered service expenses.*

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*.
2. For any portion of the charges that are in excess of the *eligible service expense.*
3. For weight modification, bariatric surgery, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery* and weight loss programs, except as specifically covered in this *contract*.
4. For breast reduction or augmentation.
5. For the reversal of sterilization and the reversal of vasectomies. Reversal of non-elective sterilizations resulting from illness or injury is covered.
6. For abortion (unless *medically necessary* or the life of the mother would be endangered if the fetus were carried to term).
7. For artificial insemination (AI), assisted reproductive technology (ART) procedures or the diagnostic tests and drugs to support AI or ART procedures.
8. For expenses for television, telephone, or expenses for other persons.
9. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
10.
11. For telephone consultations, except those meeting the definition of telehealth services, or for failure to keep a scheduled appointment.
12. For stand-by availability of a *medical practitioner* when no treatment is rendered.
13. For *dental service expenses,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Medical Service Benefits.
14. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *contract* or is performed to correct a birth defect.
15. For cosmetic breast reduction or augmentation, except for the Medically Necessary treatment of Gender Dysphoria.
16. For diagnosis or treatment of nicotine addiction, except as otherwise covered under the Preventive Care Expense Benefits provision of this *policy*.
17. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Expense Benefits.
18. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness,

farsightedness, or astigmatism.

19. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
20. For vocational or recreational therapy, vocational *rehabilitation*, *outpatient* speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
21. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.
22. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
23. For hearing aids, except as expressly provided in this *contract*.
24. For the treatment of infertility except as expressly provided in this *contract.*
25. 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.
26. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of 180 consecutive days. If travel extends beyond 180 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 180 days.
27. 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.
28. As a result of:
    a. An *injury* or *illness* caused by any act of declared or undeclared war.
    b. The *member* taking part in a riot.
    c. The *member's* commission of or attempt to commit a felony, whether or not charged, or to which a contributing cause was the insured's being engaged in an illegal occupation.
29. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Miscellaneous Medical Service Expense Benefits provision.
30. For or related to surrogate parenting.
31. For or related to treatment of hyperhidrosis (excessive sweating).
32. For fetal reduction surgery.
33. Except as specifically identified as a *covered service expense* under the *contract*, services or 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.
34. As a result of any *injury* sustained while at a *residential treatment facility.*
35. For *prescription drugs* for any *member* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later date.
36. For the following miscellaneous items: artificial insemination (except where required by federal or state law); blood and blood products; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot

orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *rehabilitation* services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service area; sclerotherapy for varicose veins ; treatment of spider veins; transportation expenses, unless specifically described in this *contract*.

37. For court ordered testing or care unless *medically necessary*.
38. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
39. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
40. 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.
41. Biofeedback.
42. Mental Health Services are excluded:
    a. For 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 Plan 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 Plan Physician determines such Services to be Medically Necessary.
    c. Court-ordered testing and testing for ability, aptitude, intelligence or interest.

TERMINATION

Termination of Contract

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date we receive a request from you to terminate this *contract*, or any later date stated in your request, or if you are enrolled through the Marketplace, the date of termination that the Marketplace provides us upon your request of cancellation to the Marketplace.
3. For a Dependent Child Reaching the Limiting Age of 26, Coverage under this contract, for a Dependent Child, will terminate at 11:59 p.m. on the last day of the year in which the Dependent Child reaches the limiting age of 26.
4. The date we decline to renew this *contract*, as stated in the Discontinuance provision.
5. The date of your death, if you are the only member on this *contract*.
6. The date your eligibility for insurance under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.
7. The date your eligibility for coverage under this *Contract* ceases as determined by the Marketplace.

If this *contract* is other than an individual coverage only plan (i.e. includes family coverage), it may be continued after *your* death:

1. By *your spouse*, if a *member;* otherwise,
2. By the youngest child who is a *member.*

This *contract* will be changed to a plan appropriate, as determined by *us,* to the *member(s)* that continue to be covered under it. *Your spouse* or youngest child will replace *you* as the primary *member*. A proper adjustment will be made in the premium required for this *contract* to be continued. *We* will also refund any premium paid and not earned due to *your* death. The refund will be based on the number of full months that remain to the next premium due date.

Refund upon Cancellation

We will refund any premium paid and not earned due to *contract* termination. Y*ou* may cancel the *contract* at any time by written notice, delivered or mailed to the Marketplace, or if an off-Marketplace *member* by written notice, delivered or mailed to *us*. Such cancellation shall become effective upon receipt, or on such later date specified in the notice. If *you* cancel, *we* shall promptly return any unearned portion of the premium paid, but in any event shall return the unearned portion of the premium within 30 days. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the effective date of the cancellation.

Discontinuance

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

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

Portability of Coverage
If a person ceases to be a *member* due to the fact that the person no longer meets the definition of *dependent member* under the *contract*, the person will be eligible for continuation of coverage. If elected, *we* will continue the person's coverage under the *contract* by issuing an individual *policy*. The premium rate applicable to the new *policy* will be determined based on the *residence* of the person continuing coverage. All other terms and conditions of the new *policy*, as applicable to that person, will be the same as this *contract*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new *contract* to the extent satisfied under this *contract* at the time that the continuation of coverage is issued. (If the original coverage contains a family *deductible* which must be met by all *members* combined, only those expenses incurred by the *member* continuing coverage under the new *contract* will be applied toward the satisfaction of the *deductible amount* under the new *contract*.)

Reinstatement
If any premium is not paid by the end of the grace period *your* coverage will terminate. Later acceptance of premium by *us*, within four calendar days of the end of the grace period, will reinstate *your policy* with no break in *your* coverage. *We* will refund any premium that *we* receive after this four-day period.

Reinstatement shall not change any provisions of the *policy*.

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

CLAIMS

Notice of Claim
We must receive notice of claim within 30 days of the date the *loss* began or as soon as reasonably possible. Notice given by or on behalf of *you* at 11720 Borman Drive, St. Louis, MO 63146, or to any authorized agent of *ours*, with information sufficient to identify *you*, will be deemed notice to *us*.

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

Proof of Loss
Written proof of loss must be furnished to *us* in case of claim for loss for which this *policy* provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

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

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

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

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

Time for Payment of Claims
Benefits will be paid immediately upon receipt of *proof of loss*. Should we determine that additional supporting documentation is required to establish responsibility of payment, we shall pay benefits upon receipt of such additional supporting documentation.

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

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

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

If a proper claim is submitted by a public hospital or clinic, benefits payable will be paid to such hospital or clinic with or without an assignment from *you* or *your dependent*. Payment of benefits to the public hospital or clinic pursuant to this paragraph shall discharge us from all liability to *you* or *your dependent* to the extent of benefits paid.

Foreign Claims Incurred For Emergency Care
Claims incurred outside of the United States for *emergency* care and treatment of a *member* must be submitted in English or with an English translation. Foreign claims must include the applicable medical records in English to show proper *proof of loss*.

Assignment
We will reimburse a *hospital* or health care provider if:
1. *Your* health insurance benefits are assigned by *you* in writing; and
2. *We* approve the assignment.

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

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

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

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

Physical Examination
We have the right and opportunity to examine a *member* while a claim is pending or while a dispute over the claim is pending. These examinations are made at *our* expense and as often as *we* may reasonably require. *We*, at our own expense, have the right and opportunity to make an autopsy of *member* in case of death where it is not forbidden by law.

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

No Third Party Beneficiaries
This *contract* is not intended to, nor does it, create or grant any rights in favor of any third party, including but not limited to any *hospital, provider* or *medical practitioner* providing services to *you*, and this *contract* shall not be construed to create any third party beneficiary rights.

COMPLAINT AND APPEAL PROCESS

The following processes are available to address your problems and concerns. In addition, communicating a complaint or grievance will not affect your healthcare benefits or services and we will not treat you differently.

Call Member Services
We want to know your concerns so we can improve our services. Please contact our Member Services team at 1-855-650-3789 (TDD/TYY) 1-877-250-6113 if you have questions or concerns.
We will attempt to resolve your concern on your initial contact.

If we need additional time to review your concern/complaint, we will provide a written response to your complaint within twenty (20) business days after receipt of your complaint or within thirty (30) calendar days, whichever is less

If you are not satisfied with our response or decision, you may file an appeal. For adverse determinations, your provider also has the opportunity to request a review with the Ambetter from Home State Health clinician who made the decision or a clinical peer.

Who Can File an Appeal
You have the right to have someone else help you with filing an appeal. This can be a relative, friend, lawyer, your doctor or health care provider, or other person. To have someone else file an appeal for you, we must have your written permission for that person to file an appeal on your behalf. You will need to obtain and fill out an Authorized Representative Form and return it to us so we will know who you have granted permission to represent you. The Authorized Representative Form can be obtained by calling Member Services at 1-855-650-3789 (TDD/TTY) 1-877-250-6113 or by visiting our website at ambetter.homestatehealth.com.

Appeal Process

An Appeal may be filed related to an availability, delivery, or quality of health care service; an adverse determination regarding a utilization review; claims payment; or contractual benefits.

Rescission of coverage: If we rescind (withdraw) your coverage, you may file an appeal according to the following procedures. We cannot terminate your benefits until all of the appeals have been exhausted. Since a rescission means that no coverage ever existed, if our decision to rescind is upheld, you will be responsible for payment of all claims for your health care services.

You have up to 180 calendar days to file an Appeal from the date you receive the decision that you are requesting be overturned. An Appeal may be filed in writing by mail or by fax at 1-855-805-9812. Please send your written Appeal to:

Grievances and Appeals Coordinator
Ambetter from Home State Health
11720 Borman Drive
St. Louis, MO 63146
When filing your Appeal, we ask that you provide a reason along with any information to support why your Appeal should be approved. If you need assistance in filing an appeal, we will accommodate, including filing an Appeal by telephone. You may call the Member Services number on your identification card or as communicated in this document.

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

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

If you file an Appeal, an acknowledgement letter will be sent within ten (10) business days from when the Appeal was received by Ambetter from Home State Health.

The Appeal investigation will be completed and response provided within twenty (20) business days after receipt of your Appeal or within thirty (30) calendar days, whichever is less. If additional time is needed and agreed upon by you, you will be notified in writing before the twentieth (20th) business day with specific reasons why the additional time is needed and the additional time will be no greater than fourteen (14) calendar days. The appeal decision response will be provided in writing.

Expedited Appeal Review
You or your representative or provider acting on your behalf may request an expedited Appeal review when a non-expedited review would reasonably appear to seriously jeopardize the life or health of the member or jeopardize the member's ability to regain maximum function. A request for an expedited review may be submitted orally or in writing.

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

We will notify you orally of the decision for an expedited appeal request within seventy-two (72) hours,

and provide the appeal decision response no more than three (3) working days after that.

Access to Documents Relevant to the Appeal
You are entitled to receive, upon request and at no additional cost, reasonable access to and copies of all documents relevant to the appeal including any new or additional evidence. Relevant documents include documents and records relied upon in making the appeal decision and documents and records submitted in the course of making the appeal decision.

Filing a Complaint or Appeal with the Missouri Department of Insurance, Financial Institutions and Professional Registration

You have the right to file a Complaint or Appeal with the Missouri Department of Insurance, Financial Institutions and Professions Registration at any time. The Missouri Department of Insurance may be contacted at the following address and telephone number:

Missouri Department of Insurance, Financial Institutions and Professional Registration
Attn: Division of Consumer Affairs
P.O. Box 690
Jefferson City, MO 65102
Phone: 1-800-726-7390

Request for External Review by an Independent Review Organization
If the Missouri Department of Insurance, Financial Institutions and Professional Registration is unable to resolve your Complaint or Appeal regarding the medical necessity, appropriateness, health care setting, level of care, or effectiveness of healthcare service, The Missouri Department of Insurance, Financial Institutions and Professional Registration may select an Independent Review Organization (IRO) to conduct an external review.

For the purposes of the appeals process, an Independent Review Organization (IRO) means an entity that is accredited by a nationally recognized private accrediting organization to conduct independent external reviews of adverse benefit determinations and by the Missouri Department of Insurance, Financial Institutions and Professional Registration in accordance with Missouri law. The IRO is composed of persons who are not employed by Ambetter from Home State Health or any of its affiliates.

The IRO will provide you with a written notice of its decision to either uphold or reverse our adverse benefit determination no later than forty-five (45) calendar days of receipt of your external review request (not urgent).

If an expedited external review (urgent) was requested by the Missouri Department of Insurance, Financial Institutions and Professional Registration, the IRO will provide a determination as soon as possible or within seventy-two (72) hours of receipt of the expedited request.

The IRO's decision is binding on us.

If we decide to reverse our adverse determination before or during the external review, we will notify you and the Missouri Department of Insurance, Financial Institutions and Professional Registration within one business day of the decision.

If the IRO reverses our decision, we will immediately provide coverage for the health care service or services in question.

If the IRO and Missouri Department of Insurance upholds our decision, you may have a right to file a lawsuit in any court having jurisdiction.

GENERAL PROVISIONS

Entire Contract

This *contract,* with the application*, schedule of benefits* and any rider-amendments is the entire contract between *you* and *us.* No change in this *contract* will be valid unless it is approved by one of *our* officers and noted on or attached to this *contract.* No agent may:

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

Non-Waiver

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

Rescissions

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

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

Repayment for Fraud, Misrepresentation or False Information

During the first two years a *member* is covered under the *contract*, if a *member* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *member* under this *contract* or in filing a claim for *contract* benefits, *we* have the right to demand that *member* pay back to *us* all benefits that *we* provided or paid during the time the *member* was covered under the *contract*.

Time Limit on Certain Defenses

After two years from the date of issue of this *policy* no misstatements, except fraudulent misstatements, made by *you* in the application for *your policy* may be used to void *your policy* or to deny a claim for loss incurred commencing after the expiration of such two-year period. In accordance with the foregoing, *we* have the right to terminate this *contract* if *you* commit fraud or make a material misrepresentation during the application process, or *we* determined it appropriate to comply with law.

No claim for loss incurred commencing after two years from the date of issue of this *contract* will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the *effective date* of coverage of this *contract*.

Conformity with State Laws

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

Statement of Non-Discrimination

Ambetter from Home State Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from Sunshine Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Home State Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Ambetter from Home State Health at 1-855-650-3789 (TTY/TDD 1-877-250-6113).

If you believe that Ambetter from Home State Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Grievance/Appeals Home State Health, 11720 Borman Drive, St. Louis, MO 63146, 1-855-650-3789 (TTY/TDD 1-877-250-6113), Fax 1-866-390-4429. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from Home State Health is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Declaración de no discriminación

Ambetter de Home State Health cumple con las leyes de derechos civiles federales aplicables y no discrimina basándose en la raza, color, origen nacional, edad, discapacidad, o sexo. Ambetter de Home State Health no excluye personas o las trata de manera diferente debido a su raza, color, origen nacional, edad, discapacidad, o sexo.

Ambetter de Home State Health:

- Proporciona ayuda y servicios gratuitos a las personas con discapacidad para que se comuniquen eficazmente con nosotros, tales como:
    - Intérpretes calificados de lenguaje por señas
    - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Proporciona servicios de idiomas a las personas cuyo lenguaje primario no es el inglés, tales como:
- Intérpretes calificados
- Información escrita en otros idiomas

Si necesita estos servicios, comuníquese con Ambetter de Home State Health a 1-855-650-3789 (TTY/TDD 1-877-250-6113).

Si considera que Ambetter de Home State Health no le ha proporcionado estos servicios, o en cierto modo le ha discriminado debido a su raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja ante: Grievance/Appeals Home State Health, 11720 Borman Drive, St. Louis, MO 63146, 1-855-650-3789 (TTY/TDD 1-877-250-6113), Fax 1-866-390-4429. Usted puede presentar una queja por correo, fax, o correo electrónico. Si necesita ayuda para presentar una queja, Ambetter de Home State Health está disponible para brindarle ayuda. También puede presentar una queja de violación a sus derechos civiles ante la Oficina de derechos civiles del Departamento de Salud y Servicios Humanos de Estados Unidos (U.S. Department of Health and Human Services), en forma electrónica a través del portal de quejas de la Oficina de derechos civiles, disponible en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* o por correo o vía telefónica llamando al: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Los formularios de queja están disponibles en *http://www.hhs.gov/ocr/office/file/index.html.*

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Home State Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Home State Health 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-855-650-3789 (TTY/TDD 1-877-250-6113)。
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Home State Health, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Serbo-Croatian:	Ako Vi, ili neko kome pomažete, imate pitanja u vezi Ambetter from Home State Health, imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-855-650-3789 (TTY/TDD 1-877-250-6113).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Home State Health hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-855-650-3789 (TTY/TDD 1-877-250-6113) an.
Arabic:	اذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Home State Health، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Home State Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-855-650-3789 (TTY/TDD 1-877-250-6113)로 전화하십시오.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Home State Health вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-855-650-3789 (TTY/TDD 1-877-250-6113).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Home State Health, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Tagalog:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from Home State Health के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-855-650-3789 (TTY/TDD 1-877-250-6113) पर कॉल करें।
Pennsylvania Dutch:	Vann du, adda ebbah's du am helfa bisht, ennichi questions hott veyyich Ambetter from Home State Health, dann hosht du's recht fa hilf greeya adda may aus finna diveyya in dei shprohch un's kosht nix. Fa shvetza mitt ebbah diveyya, kawl 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Persian:	اگر شما، یا کسی که به او کمک می کنید سوالی در مورد Ambetter from Home State Health دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. براي صحبت کردن با مترجم با شماره 1-855-650-3789 (TTY/TDD 1-877-250-6113) تماس بگیرید.
Cushite:	Yoo sii ykn namaa gargaaraa jirtuu wa'ee Ambetter from Home State Health irra gaaffi qabaatan ta'ee gargaarsaa fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana wajiin dubadhuu,1-855-650-3789 irra bilbilli (TTY/TDD 1-877-250-6113).
Portuguese:	Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Ambetter from Home State Health, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-855-650-3789 (TTY/TDD 1-877-250-6113).
Amharic:	አርስዎ ወይም አርስዎ የሚረዱት ሰው ስለ Ambetter from Home State Health ጥበር ጥያቄ ካለዎት ያለምንም ወጪ በቋንቋዎ ድጋፍ እንዲሁም መረጃ የማግኘት መብት አለዎት፣ ለአተርጓሚ ለማነጋገር በ 1-855-650-3789 (TTY/TDD 1-877-250-6113) ይደውሉ፣ ፣

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