ambetter. FROM buckeye health plan

2019 Evidence of Coverage

Ambetter.BuckeyeHealthPlan.com

41047OH002-2019

Ambetter Individual Health Benefit Plan
Issued and underwritten by Buckeye Community Health Plan

Home Office: 4349 Easton Way, Suite 300, Columbus, OH, 43219

Individual Member Contract

In this *contract*, the terms "*you*," "*your*," or "*yours*" will refer to the *member* or any *dependents* enrolled in this *contract*. The terms "*we*," "*our*," or "*us*" will refer to Buckeye Community Health Plan.

AGREEMENT AND CONSIDERATION

In consideration of *your* application and the timely payment of premiums, *we* will provide benefits to *you*, the *member*, for covered *loss* 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 moved 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 a material misrepresentation made by or with the knowledge of a *member* in filing a claim for *contract* benefits.

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 after filing and approval by the state.

At least 31 day 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.

Referrals are not required for *you* to access a *specialist* or *other practitioner* care within the *network*. Referrals for out-of-network services must always be reviewed by the health plan for medical necessity determination and *in-network provider* availability for benefits to be payable under *your contract* or benefits payable under this *contract* will be denied.

This *contract* is not a Medicare supplement *contract*. If *you* are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from the company.

COORDINATION OF BENEFITS

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTHCARE 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. READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

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*.

Buckeye Community Health Plan

Steven B. Province, President and CEO

Table of Contents

Introduction

Welcome to Ambetter from Buckeye Health Plan! *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 costs *you* will be required to pay.

This *contract*, the *Schedule of Benefits*, and application attached shall constitute the entire *contract* under which *covered services* and supplies are provided or paid for by *us*.

Because many of the provisions are interrelated, *you* should read this entire *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* in the Definitions section. This *contract* also contains exclusions, so please be sure to read this entire *contract* carefully.

How To Contact Us
Ambetter from Buckeye Health Plan
4349 Easton Way, Suite 300
Columbus, OH, 43219

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. EST, Monday through Friday
Member Services **1-877-687-1189**
TTY/TDD line **1-877-941-9236**
Fax **1-877-941-8076**
Emergency **911**
24/7 Nurse Advice Line **1-877-687-1189**

Interpreter Services
Ambetter from Buckeye Health Plan has a free service to help *our members* who speak languages other than English. This service allows *you* and *your provider* 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 representatives that speak Spanish and 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 an oral interpretation. To arrange for interpretation services, please call Member Services at 1-877-687-1189 (TTY/TDD 1-877-941-9236).

Member Rights and Responsibilities

We are committed to:

1. Recognizing and respecting *you* as a *member*.
2. Encouraging open discussions between *you*, *your physician* and *medical practitioners*.
3. Providing information to help *you* become an informed healthcare consumer.
4. Providing access to *covered services* and *our network providers*.
5. Sharing *our* expectations of *you* as a *member*.

You have the right to:

1. Participate with *your physician* and *medical practitioners* in decisions about *your* healthcare. 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 provider* about what might be wrong (to the level known), treatment and any known likely results. *Your primary care provider* 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 provider* will ask for *your* approval for treatment unless there is an emergency and *your* life and health are in serious danger.
8. Make recommendations regarding *member's* rights, responsibilities, and policies.
9. Voice *complaints* or 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 provider*(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 provider* assignment, *providers*, advance directive information, referrals and *prior authorizations*, benefit denials, *member* rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such notices shall include the following:
    a. Any changes in clinical review criteria; and
    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*. A listing of *network providers* is available online at Ambetter.BuckeyeHealthPlan.com. *You* can find any of *our network providers* by visiting *our* website and using the "Find a Provider" function. *You* can also get information on *your network providers'* education, training, and practice.
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, ethnicity, race, gender, sex, sexual orientation, disability, national origin, or religion.
16. Access *medically necessary emergency services* 24 hours a day and seven days a week.

17. Access *medically necessary urgent care* through *network providers* 24 hours a day and seven days a week, including our 24/7 Nurse Advice Line.
18. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
19. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *primary care provider*'s instructions are not followed. *You* should discuss all concerns about treatment with *your primary care provider*. *Your primary care provider* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
20. Select *your primary care provider* within the *network*. *You* also have the right to change *your primary care provider* or request information on *network providers* close to *your* home or work.
21. Know the name and job title of people giving *you* care. *You* also have the right to know which *provider* is your *primary care provider*.
22. An interpreter when *you* do not speak or understand the language of the area.
23. A second opinion by a *network provider,* if *you* want more information about *your* treatment or would like to explore additional treatment options.
24. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it.
25. Advance directives are forms *you* can complete to protect *your* rights for medical care. It can help *your primary care provider* and other *providers* understand *your* wishes about *your* health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for *yourself*. Examples of advance directives include:
    a. Living Will;
    b. Health Care Power of Attorney; or
    c. "Do Not Resuscitate" Orders. *Members* also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this entire *contract*.
2. Treat all *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 provider* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* ID card and keep scheduled appointments with *your provider*, and call the *provider*'s office during office hours whenever possible if *you* have a delay or cancellation.
6. Know the name of *your* assigned *primary care provider*. *You* should establish a relationship with *your provider*. *You* may change *your primary care provider* 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 healthcare professionals* and *providers* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your healthcare professionals* and *providers* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your healthcare professionals* and *providers*.
11. Tell *your healthcare professional* and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care provider* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
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 provider*.

14. When *you* enroll in this coverage, give all information about any other medical coverage *you* have. If, at any time, *you* get other medical coverage besides this coverage, *you* must tell the entity with which *you* enrolled.
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 *contract* if *you* have any change to *your* name, address, or family members covered under this *contract* within 60 days from the date of the event.

Continuity of Care

If *your provider* is terminated without cause from *our* network, *you* have the right to continue with an active course of treatment until the treatment is complete or for 90 days, whichever is shorter, at *in-network cost sharing* rates.

Active course of treatment means:

- An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;
- An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits;
- The second or third trimester of pregnancy, through the postpartum period; or
- An ongoing course of treatment for a health condition for which a treating *physician* or health care *provider* attests that discontinuing care by that *physician* or health care *provider* would worsen the condition or interfere with anticipated outcomes.

We will notify *you* by mail within 30 days of the termination of a contract with a *primary care provider* if *you*, or a *dependent member*, has received health care services from *your primary care provider* within the previous 12 months or if you or your *dependent member* has selected the *provider* as your *primary care provider* within the previous 12 months.

We will notify *you* by mail within 30 days of the termination of a contract with a *hospital* if *you*, or a *dependent member*, has received health care services from that *hospital* within the previous 12 months.

We will pay, in accordance with the terms of the contract, for all covered health care services rendered to a *member* by a *primary care provider* or *hospital* between the date of the termination of the contract and 5 days after the notification of the contract termination is mailed to a *member* at the *member's* last known address.

Your Provider Directory

A listing of *network providers* is available online at Ambetter.BuckeyeHealthPlan.com. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* healthcare services. *You* can find any of *our network providers* by visiting *our* website and using 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 printed copy of the provider directory at no charge by calling Member Services at 1-877-687-1189 (TTY/TDD 1-877-941-9236). In order to obtain benefits, *you* must designate a *network primary care provider* for each *member*. *We* can help *you* pick a *primary care provider* (PCP). *We* can make *your* choice of *primary care provider* effective on the next business day.

Call the *provider's* office if *you* want to make an appointment. If *you* need help, call Member Services at 1-877-687-1189 (TTY/TDD 1-877-941-9236). *We* will help *you* make the appointment.

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

The ID card will show *your* name, member ID#, and any *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 1-877-687-1189 (TTY/TDD 1-877-941-9236), twenty-four hours per day, seven days a week. *We* will send *you* another card.

Our Website
Our website can answer many of *your* frequently asked questions. *Our* website has resources and features that make it easy to get quality care. *Our* website can be accessed at Ambetter.BuckeyeHealthPlan.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. *Deductible* and *copayment* Accumulators.
8. *Our* Formulary or Preferred Drug List.
9. Selecting a *Primary Care Provider*.

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 *providers* 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, cervical cancer screening, breast cancer screening, and immunizations.
5. Monitoring the quality of care and developing action plans to improve the healthcare *you* are receiving.
6. A Quality Improvement Committee which 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 provider* or service provided by *us*, please contact the Member Services Department at **1-877-687-1189 (TTY/TDD 1-877-941-9236)**.

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 *covered person* 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 any of the following:

a. *Adverse benefit determination* means a decision by a health plan issuer:
    1. To deny, reduce, or terminate a requested healthcare service or payment in whole or in part, including all of the following:
        a. A determination that the healthcare service does not meet the health plan issuer's requirements for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness, including *experimental* or *investigational treatments*;
        b. A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a nonemployer group, to participate in a plan or health insurance coverage;
        c. A determination that a healthcare service is not a covered benefit;
        d. The imposition of an exclusion, including an exclusion for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.
    2. Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a nonemployer group;
    3. To rescind coverage on a health benefit plan.

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

Affordable Care Act "ACA" means the comprehensive healthcare reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law. This is often times referred to as Health Care Reform.

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.

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

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.

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

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

1. A person to whom a *you* have given express, written consent to represent *you* 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 *you* ;
3. A family member or a treating health care professional, but only when *you* are unable to provide consent.

Autism spectrum disorder refers to a group of complex disorders represented by repetitive and characteristic patterns of behavior and difficulties with social communication and interaction. The symptoms are present from early childhood and affect daily functioning as defined by the most recent edition of the Diagnostic and Statistical manual of Mental Disorders and the International Classification of Diseases.

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.

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.

Cardiac rehabilitation means to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning, and maintenance are not covered.

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

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of transplants or 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*.

Chemotherapy means the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.

Chiropractic Care involves neuromuscular treatment in the form of manipulation and adjustment of the tissues of the body, particularly of the spinal column, and may include physical medicine modalities or use of *durable medical equipment*.

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

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

Complications of pregnancy means:

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 and surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, provider prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct *complication of pregnancy*.
2. An emergency caesarean section or a *non-elective caesarean section*.

Contract 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.

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*** are healthcare services, supplies or treatment described in this *contract* which are performed, prescribed, directed, or *authorized* by a *provider*. To be a *covered service* the service, supply, or treatment must be:

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

Custodial care 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.

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

Deductible amount or ***Deductible*** means the amount that *you* must pay in a calendar year for *covered 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 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.

Dental services 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 spouse* or an *eligible child*.

Diagnostic services means tests or procedures performed when you have specific symptoms, to detect or monitor your condition.
1. X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
2. Magnetic Resonance Angiography (MRA).
3. Magnetic Resonance Imaging (MRI).
4. CAT scans.
5. Laboratory and pathology services.
6. Cardiographic, encephalographic, and radioisotope tests.
7. Nuclear cardiology imaging studies.
8. Ultrasound services.
9. Allergy tests.
10. Electrocardiograms (EKG).
11. Electromyograms (EMG) except that surface EMG's are not *covered services*.
12. Echocardiograms.
13. Bone density studies.
14. Positron emission tomography (PET scanning).
15. Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
16. Echographies.
17. Doppler studies.
18. Brainstem evoked potentials (BAER).
19. Somatosensory evoked potentials (SSEP).
20. Visual evoked potentials (VEP).
21. Nerve conduction studies.
22. Muscle testing.
23. Electrocorticograms.
24. Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a *hospital* or *provider's* office.

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

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 *illness* or *injury*.

Eligible cancer clinical trial means a cancer clinical trial that meets all of the following criteria:

1. A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
2. The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
3. The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
4. The trial does one of the following:
    a. Tests how to administer a healthcare service, item, or drug for the treatment of cancer;
    b. Tests responses to a healthcare service, item, or drug for the treatment of cancer;
    c. Compares the effectiveness of a healthcare service, item, or drug for the treatment of cancer with that of other healthcare services, items, or drugs for the treatment of cancer; or
    d. Studies new uses of a healthcare service, item, or drug for the treatment of cancer.
5. The trial is approved by one of the following entities:
    a. The National Institutes of Health or one of its cooperative groups or centers under the United States Department of Health and Human Services;
    b. The United States Food and Drug Administration;
    c. The United States Department of Defense; or
    d. The United States Department of Veterans' Affairs.
6. A medical professional has determined the cancer clinical trial is appropriate for the *member*.

Eligible child means *your* or *your spouse's* child, 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 stepchild;
4. A child placed with *you* for adoption; or
5. 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* provide or pay for a child at a time when the child did not qualify as an *eligible child*.

Eligible service expense means a *covered service expense* 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 as outlined under (a) through (g) of the Emergency Services provision within this *contract*, 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 as payment in full, 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.

b. When a *covered service* is received from a *non-network provider* as a result of an emergency not outlined in (2)(a) above, the *eligible service expense* is determined based on the greatest amount of the following:
    i. the negotiated fee that has been agreed upon by *us* and the provider (*you* may be billed for the difference between the negotiated fee and the provider's charge);
    ii. 100% of the fee Medicare allows for the same or similar services provided in the same geographical area; or
    iii. The fee established by *us* by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by *us*.

c. When a *covered service* is received from a *non-network provider* that is not the result of an emergency and there is not an appropriate *network provider* available to render the *covered service*, 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 as payment in full, 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. *You* must receive *prior authorization* or *approval* from *us*, prior to receiving the service.

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

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

Emergency health services means those health care services that must be available on a seven-days-per-week, twenty-four hours-per-day basis in order to prevent jeopardy to an enrollee's health status that would occur if such services were not received as soon as possible, and includes, where appropriate, provisions for transportation and indemnity payments or service agreements for out-of-area coverage.

Essential Health Benefits provided within this *contract* are not subject to lifetime or annual dollar maximums. Certain non-*essential health benefits*, however, are subject to either a lifetime and/or annual dollar maximum. *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.

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. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug 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; or

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 abuse*, *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 a health plan issuer's 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 healthcare service, supply, or drug is *medically necessary* and is a *covered service* under the *contract*. 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 means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in any form to the insurer by, or on behalf of, a claimant including any of the following:
1. Quality of care;
2. Provider behavior;
3. Waiting times for services; or
4. Involuntary disenrollment.

Habilitation means *medically necessary* habilitative services and devices which are health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and

occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

Healthcare provider or ***provider*** means a *healthcare professional* or facility.

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*.

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

Hospice means 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.

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*.

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 superintendent of insurance in accordance with Ohio law.

Inhalation therapy means the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. *Covered services* include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

In-network means services provided by a *network provider* (or *preferred provider*).

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

Inpatient services 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. This includes:

1. Charges from a *hospital*, *skilled nursing facility* (SNF) or other *provider* for room, board and general nursing services.
2. Ancillary (related) services.
3. Professional services from a *provider* while an inpatient.

Room, Board, and General Nursing Services include:

1. A room with two or more beds.
2. A private room. The private room allowance is the *hospital's* average semi-private room rate unless it is *medically necessary* that *you* use a private room for isolation and no isolation facilities are available.
3. A room in a special care unit approved by *us*. The unit must have facilities, equipment, and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services include:

1. Operating, delivery and treatment rooms and equipment.
2. Prescribed drugs.
3. Anesthesia, anesthesia supplies, and services given by an employee of the *hospital* or other *provider*.
4. Medical and surgical dressings, supplies, casts, and splints.
5. *Diagnostic services*.
6. Therapy services.

Professional Services include:

1. Medical care visits limited to one visit per day by any one *physician*.
2. Intensive medical care for constant attendance and treatment when *your* condition requires it for a prolonged time.
3. Concurrent care for a medical condition by a *physician* who is not *your* surgeon while *you* are in the *hospital* for *surgery*. Care by two or more *physicians* during one *hospital* stay when the nature or severity of *your* condition requires the skills of separate *physicians*.
4. Consultation which is a personal bedside examination by another *physician* when requested by *your physician*. Staff consultations required by *hospital* rules; consultations requested by the patient; routine

radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
5. *Surgery* and the administration of general anesthesia.
6. Newborn exam. A *physician* other than the *physician* who performed the obstetrical delivery must do the examination.

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

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

Licensed Mental Health Professional means a professional that holds a clinical license in a behavioral health discipline; and possesses the training or experience to complete the required evaluation and treatment of behavioral health disorders.

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

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).

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

Manipulation therapy includes osteopathic/chiropractic manipulation therapy used for treating problems associated with bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for *manipulation therapy* services as specified in the *Schedule of Benefits*. *Manipulation therapy* services rendered in the home as part of *home care services* are not covered.

Maximum out-of-pocket amount is the sum of the *deductible amount*, *prescription drug deductible amount* (if applicable), *copayment amount* and *coinsurance* percentage of *covered expenses*, as shown in the *Schedule of Benefits*. After the *maximum out-of-pocket amount* is met for an individual, Buckeye Community Health Plan pays 100% of *eligible service 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 *covered persons' eligible service 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.

The Dental out-of-pocket maximum limits do not apply to the satisfaction of the *maximum out-of-pocket* per calendar year as shown in the *Schedule of Benefits*.

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

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

Medical practitioner means, but is not limited to, a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. 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. The following are examples of providers that are NOT *medical practitioners*, by definition of the *contract*: acupuncturist, speech therapist, occupational therapist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, emergency medical technician, social worker, family counselor, marriage counselor, child counselor, naturopath, perfusionist, massage therapist, or sociologist.

Medically necessary means any medical service, supply, or treatment *authorized* by a *provider* 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 *provider* or the *member*;
5. Is not *experimental* or *investigational*;
6. Is provided in the most cost effective care facility or setting;
7. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; and
8. When specifically applied to a *hospital* confinement, it means that the diagnosis and treatment of *your* medical symptoms or conditions cannot be safely provided as an outpatient.

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

Medically necessary medical supplies mean medical supplies that are:

1. *Medically 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.

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

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 opt-out practitioner means a *medical practitioner* who:

1. Has filed an affidavit with the Department of Health and Human Services stating that he or she will not submit any claims to Medicare during a two-year period; and
2. Has been designated by the Secretary of that Department as a *Medicare opt-out practitioner*.

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 *you*, *your spouse*, and each *eligible child*:
1. Named in the application; or
2. Whom *we* agree in writing to add as a *member*.

Mental health disorder refers to a behavioral, emotional, or cognitive pattern of functioning that is 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 (ICD-10).

Minimum Essential Coverage (MEC) means any insurance plan that meets the *Affordable Care Act* requirement for having health coverage. To avoid the penalty for not having insurance, *you* must be enrolled in a plan that qualifies as *minimum essential coverage* (sometimes called "qualifying health coverage"). Examples of plans that qualify include: Marketplace plans, job-based plans (including COBRA coverage), Medicare, and Medicaid and CHIP.

Network means a group of *physicians* and *providers* who have contracts that include an agreed upon price for healthcare services or expenses.

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

Network provider (or ***preferred provider***) means a *physician* or *provider* who is identified in the most current list for the *network* shown on *your* identification card. Services received from a *network provider* are "*in-network*". These *providers* will be identified in the most current Provider Directory for the *network*.

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 eligible service expense means the *eligible service expense* for services or supplies that are provided and billed by a *non-network provider*.

Non-network provider (or ***non-preferred provider***) means a *physician* or *provider* who is <u>NOT</u> identified in the most current list for the *network* shown on *your* identification card. Services received from a *non-network provider* are "out-of-network" and are not covered, except as specifically stated in this *contract*.

Occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. *Occupational therapy* does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non *covered services* include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation, and other types of similar equipment.

Oral chemotherapy means the treatment with drugs given by mouth to kill cancer cells or stop them from dividing.

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

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 healthcare system. A *pain management program* must be individualized and provide physical *rehabilitation*, education on pain, relaxation training, and medical evaluation.

Physical therapy including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following *illness*, *injury*, or loss of a body part. Non *covered services* include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or *illness*; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.

Physician or ***Provider*** 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 benefits for medical care or treatment that is not a *pre-service claim*.

Pre-service claim means any claim for benefits for medical care or treatment that requires the *approval* of the plan in advance of the claimant obtaining the medical care.

Predetermination means a written request by the *member* to determine if a proposed treatment or service by the *member's PCP* or *provider* is covered under the *contract*. This process is voluntary and the *predetermination* is dependent upon complete and accurate information submitted before the services are rendered. Payment is dependent upon the information submitted after the services are rendered.

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." This also includes over-the-counter drugs prescribed by a *provider*.

Prescription drug deductible amount means the amount of *covered 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 *covered person* 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 *covered persons' eligible service 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 or ***PCP*** 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.

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

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

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

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

Pulmonary rehabilitation means to restore an individual's functional status after an *illness* or *injury*. *Covered services* include but are not limited to outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is *inhalation therapy* administered in *physician's* office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. *Pulmonary rehabilitation* in the acute inpatient rehabilitation setting is not a *covered service*.

Qualified health plan or ***QHP*** means a health plan that has in effect a certification that it meets the standards issued or recognized by each Health Insurance Marketplace through which such plan is offered.

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.

Radiation therapy means the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.

Reconstructive surgery means *surgery* performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including *surgery* after a mastectomy, 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 includes *acute rehabilitation*, *sub-acute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy* and *pain management programs*.

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

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

Rescission of a policy means a cancellation or discontinuance of coverage that has a retroactive effect. *Rescission* does not include a cancellation or discontinuance or 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.

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, including those for treatment of mental health and substance use disorders, 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.

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 Ohio 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* healthcare services and supplies. *You* can receive precise *service area* boundaries from *our* website or *our* Member Services department.

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.

Skilled Nursing Facility means a provider constituted, licensed, and operated as set forth in applicable state law, which:

1. mainly provides inpatient care and treatment for persons who are recovering from an *illness* or *injury*;

2. provides care supervised by a *physician*;
3. provides 24 hour per day nursing care supervised by a full-time registered nurse;
4. is not a place primarily for care of the aged, custodial or domiciliary care, or treatment of alcohol or drug dependency; and
5. is not a rest, educational, or custodial *provider* or similar place.

Specialist provider is 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.

Speech therapy for the correction of a speech impairment.

Spouse means the person to whom *you* are lawfully married.

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

1. Placing the health of the individual or, with respect to a pregnant person, the health of the person or the unborn child, in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part; or
4. In the case of a person having contractions, *stabilize* means such medical treatment as may be necessary to deliver, including the placenta.

Sub-acute rehabilitation means one or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for one-half hour to two hours per day, five to seven days per week, while the *covered person* 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* include 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 six months or less to live.

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

Tobacco 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.

***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.

***Urgent care* service** means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay, but that does not pose a threat to the life, limb, or permanent health of the injured or ill person, and may include such health care services provided out of *our* approved service area pursuant to indemnity payments or service agreements.

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

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

You means a policyholder, subscriber, enrollee, *member*, or individual covered by a health benefit plan. *You* does include *your authorized representative* with regard to an internal appeal or external review in accordance with subsection (C) of the Internal Claims and Appeals Procedures and External Review section. *You* does not include *your* representative in any other context.

Dependent Member Coverage

Dependent Member Eligibility
Your dependent members become eligible for coverage under this *contract* on the latter of:

1. The date *you* became covered under this *contract*; or
2. The first day of the premium period/first full calendar month after the date of becoming *your dependent*.

Effective Date for Initial Dependent Members
The *effective date* for *your* initial *dependent members* 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*.

Adding a Newborn Child
An *eligible child* born to *you* or a family *member* will be covered from the time of birth until the 31st day after its birth.

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* enrolled (either the Marketplace or *us*).

Adding an Adopted Child
An *eligible child* legally placed for adoption with *you* or *your spouse* will be covered from the date of *placement* until the 31st 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 for *loss* due to *injury* and *illness*, including *medically necessary* care and treatment of conditions existing prior to the date of *placement*.

Additional premium will be required to continue coverage beyond the 31st 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*" the assumption and retention by *you* or *your spouse* for total or partial support of the child in anticipation of the adoption of the child.

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

Prior Coverage
If a member is confined as an inpatient in a hospital on the effective date of this agreement, and prior coverage terminating immediately before the effective date of this agreement furnishes benefits for the hospitalization after the termination of prior coverage, then services and benefits will not be covered under this agreement for that member until the member is discharged from the hospital or benefits under the prior coverage are exhausted, whichever is earlier.

Ongoing Eligibility

For All Covered Persons

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

1. The data 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*;
2. The date the *member* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact;
3. The date *we* decline to renew this *contract*, as stated in the Discontinuance provision under the Termination section;
4. The date a *member's* eligibility for coverage under this *contract* ceases due to losing network access as the result of a permanent move;
5. 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; or
6. The *member's* death.

If *you* have material modifications (examples include a change in life event such as marriage, death, or other change in family status) or questions related to *your* health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596. If you enrolled through Ambetter contact 1-877-687-1189 (TTY/TDD 1-877-941-9236).

For Dependent Members

A *dependent member* will cease to be a *member* at the end of the premium period in which he or she ceases to be *your dependent member* due to divorce or if a child ceases to be an *eligible child*. For *eligible children*, the coverage will terminate the thirty-first of December the year 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. Not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit was reached; and
2. Mainly dependent on *you* for support.

Out of Service Area Dependent Member Coverage

A *dependent member's* coverage will not cease should the *dependent member* live outside the *service area* if a court order requires the *member* to cover such *dependent member*.

Open Enrollment

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

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 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 premium tax credit* and *cost-sharing reduction* payments until the first of the next month. *We* will send written annual open enrollment notification to each *member* no earlier than September 1st, and no later than September 30th.

Special Enrollment

A *qualified individual* has 60 days to enroll as a result of one of the following events:

1. A *qualified individual* or *dependent loses minimum essential coverage*;
2. A *qualified individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption or placement for adoption;
3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
4. An individual who is released from incarceration;
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;
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* or enrollee 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.

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 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 premium tax credit* and *cost-sharing reduction* payments until the first of the next month.

Loss of Minimum Essential Coverage

Loss of Minimum Essential Coverage 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 an individual incurs a claim that would meet or exceed a lifetime limit on all benefits;
5. 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;
6. 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; and
7. 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.

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 *advanced 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 *advanced premium tax credits* on behalf of the *member* from the Department of the Treasury, and will return the *advanced 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 policyholder to pay his or her premiums and this is communicated on *your* monthly billing statements. Ambetter payment policies were developed based on guidance from the Centers for Medicare and Medicaid Services (CMS) recommendations against accepting third party premiums. Consistent with CMS guidance, the following are the only acceptable third parties who may pay Ambetter premiums on *your* behalf:

1. Ryan White HIV/AIDS program under Title XXVI of the Public Health Service Act;
2. Indian tribes, tribal organizations, or urban Indian organizations;
3. State and Federal government programs;
4. Family members; or
5. Private, not-for-profit foundations which have no incentive for financial gain, no financial relationship, or affiliation with providers of *covered services* and supplies on behalf of *members*, where eligibility is determined based on defined criteria without regard to health status and where payments are made in advance for a coverage period from the *effective date* of eligibility through the remainder of the calendar year.

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

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 *us* of *your* new *residence* within 60 days of the change. *Your* premium will be based on *your* new *residence* beginning on the first premium due date/first day of the next calendar month after the change. If *your residence* is misstated on *your* application, or *you* fail to notify *us* of a change of *residence*, *we* will apply the correct premium amount beginning on the first premium due date/first day of the first full calendar month *you* resided at that place of *residence*. If the change results in a lower premium, *we* will refund any excess premium. If the change results in a higher premium, *you* will owe *us* the additional premium.

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* may 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 services* as described in the *Schedule of Benefits* and the Medical Service and Supply Benefits section 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

Members 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

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 *maximum out-of-pocket* has been met, additional *covered service expenses* will be provided or payable at 100%.

Deductible

The *deductible amount* means the amount of *covered service expenses* that must be paid by each/all *members* before any benefits are provided or payable. 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 provided or payable will be subject to:

1. Any specific benefit limits stated in the *contract*; and
2. A determination of *eligible service expenses*.

The applicable *deductible amount*(*s*), *cost sharing* percentage, and *copayment amounts* are shown 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 service expenses* for those services or supplies. In addition to the *deductible amount*, *copayment amount*, and *cost sharing* percentage, *you* may be responsible for the difference between the *eligible service expense* and the amount the *non-network provider* bills *you* for the services or supplies (unless receiving emergency care or if use of a *non-network provider* was *authorized* by *us*). Any amount *you* are obligated to pay to the *non-network provider* in excess of the *eligible service expense* will not apply to *your deductible amount* or *maximum out-of-pocket*.

Access to Care

Primary Care Provider

In order to obtain benefits, *you* must designate a *network primary care provider* for each *member*. *You* may select any *network primary care provider* who is accepting new patients. For children, *you* may designate a pediatrician as a *network primary care provider*. *Members* may designate an OB/GYN as a *network primary care provider*. 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 calling the telephone number shown on the front page of this *contract*.

Your network *primary care provider* will be responsible for coordinating all *covered services* with other *network providers*. You do not need a referral from your network *primary care provider* for mental or behavioral health services, obstetrical or gynecological treatment and may seek care directly from a network obstetrician or gynecologist.

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.

Members are encouraged to contact their *primary care provider* for an appointment before seeking care from another *provider*. If the *primary care provider* is not available and the condition persists, call the 24/7 Nurse Advice Line, at 1-877-687-1189 (TTY/TDD 1-877-941-9236). The 24/7 Nurse Advice Line is available twenty-four (24) hours a day, seven (7) days a week. A registered nurse can help *you* decide the kind of care most appropriate for *your* specific need.

Requests for Predeterminations of Benefits

You may request a predetermination of coverage. 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 a determination within two business days after obtaining all necessary information regarding a proposed service. *We* will notify the *provider* by phone or facsimile within three business days of *our* decision. If *we* denied the predetermination, *we* will provide written or electronic confirmation within one business day of the telephone notification to *you* and the *provider*. If *you* disagree with *our* decision, *you* may appeal pursuant to the Internal Claims and Appeals Procedures and External Review section.

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*.

If *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*.

Service Area

Ambetter operates in a limited *service area*. If the subscriber moves from one county to another within the *service area*, the monthly premiums may be increased or changed. If the subscriber moves from one county in the *service area* to another that is not in the *service area*, *you* will no longer be eligible for coverage under this *contract*, and will be eligible for special enrollment into another *qualified health plan*.

Coverage Under Other Policy 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*.

Emergency Services
If *you* are experiencing an emergency, call 9-1-1 or go to the nearest *hospital*. *Emergency services* do not require *prior authorization.* If those services provided are utilized at a *non-network* hospital, and a *member* presents their self with an emergency medical condition under one of the following circumstances, emergency care will be covered under 2(a) of the *eligible service expense* definition:

a) Due to circumstances beyond the *member's* control, the *member* was unable to utilize a *network hospital's* emergency department without serious threat to life or health;
b) A prudent layperson with an average knowledge of health and medicine would have reasonably believed that, under the circumstances, the time required to travel to a *network hospital's* emergency department could result in one or more of the adverse health consequence;
c) A person authorized by us refers the member to an emergency department and does not specify a network hospital's emergency department;
d) An ambulance takes the member to a non-network hospital other than at the direction of the member;
e) The member is unconscious;
f) A natural disaster precluded the use of a network hospital's emergency department; or
g) The status of a hospital changed from network to non-network hospital with respect to emergency services during a *contract* year and no good faith effort was made by us to inform members of this change.

Should the emergency service visit at a *non-network hospital* fall outside the above circumstances, the *eligible service expense* would be covered under (2)(b) of the *eligible service expense* definition. *You* may be subject to balance billing from the *non-network provider*.

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

Urgent Care
Urgent care includes *medically necessary services*, including facility costs and supplies, or care for a condition that is not an emergency, but is an unforeseen medical *illness*, *injury*, or condition that requires immediate care when the *member's primary care provider* is unavailable or inaccessible. Urgent care is covered at network *hospitals*, *Urgent care centers*, or *network providers'* offices. Urgent care received at any *hospital* emergency department is not covered unless *authorized* in advance by *us*.

Urgent care is not covered for services received by a *non-network provider* or at an out-of-network facility.

Medical Service and Supply Benefits

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

Accidental Dental

Coverage will be provided for *dental service* expenses when a *member* suffers an *injury*, after the *member's effective date* of coverage, that results in:

1. Damage to his or her natural teeth; and
2. Expenses are incurred within twelve months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within twelve months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.

Treatment for accidental dental is limited to $3,000 per occurrence.

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*, in cases of emergency.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.
3. Transportation between *hospitals* or between a *hospital* and a *skilled nursing* or *rehabilitation facility* when *authorized* by Ambetter from Buckeye Health Plan.

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.

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 Buckeye Health Plan will not pay benefits for any of the services, treatments, items or supplies that exceed benefit limits. For example, pulmonary therapy has a limit of 20 outpatient visits per year, however, if it is rendered as part of a physical therapy (PT) visit, the visit would apply to the PT visit limit.

Chiropractic Services

We cover charges for chiropractic services. These services shall be provided at the request of the *member* who presents a condition of an orthopedic or neurological nature necessitating treatment for which falls within the scope of a licensed *medical practitioner*.

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 is also included for *eligible cancer clinical trials*. 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:

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

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

- 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's who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

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

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

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

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

Benefits for an *eligible cancer clinical trial* do not, however, include the following:

a) A health care service, item, or drug that is the subject of the cancer clinical trial or is provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
b) An *investigational* or *experimental* drug or device that has not been approved for market by the United States Food and Drug Administration;
c) Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
d) An item or drug provided by the cancer clinical trial sponsors free of charge for any patient; or
e) A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.

Contraception
All FDA-approved contraception methods (identified on www.fda.gov) are approved for *members* without *cost sharing* as required under the *Affordable Care Act*. *Members* 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*. Emergency contraception is available to *members* without a prescription and at no cost share to the *member*. For further detail, please see the definition of "Family Planning Services," below.

Diabetic Care
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 services*; 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.

Covered service expenses also include all *provider* prescribed *medically necessary* equipment and supplies used for the management and treatment of diabetes. See "Durable Medical Equipment, Prosthetics, Orthotic Devices, and Covered Medical Supply Expense Benefits" and "Preventive Care Expense Benefits". Screenings for gestational diabetes are covered under "Preventive Care Expense Benefits."

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, Orthotic Devices, and Covered Medical Supply Expense Benefits
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:

- The equipment, supply, or appliance is a *covered service*;
- The continued use of the item is *medically necessary*;

- 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 are 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:

- Repair and replacement due to misuse, malicious breakage, or gross neglect.
- 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 and supplies may include, but are not limited to:

1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for 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* and supplies include, but are not limited to:

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

Orthotic devices
Covered services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. 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 and supplies 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.

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 and supplies 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 calendar year, 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 calendar year).

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

1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports, and corsets.
4. Artificial heart implants.
5. Wigs (except as described above following cancer treatment).
6. Penile prosthesis in *members* suffering impotency resulting from disease or *injury*.

Family Planning Services
Covered service and supply expenses for family planning include:

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

5. All FDA-approved contraception methods are covered without *cost sharing* as outlined at www.fda.gov (see "Contraception" section above). This benefit contains both pharmaceutical and medical methods, including, but not limited to:
    a. Intrauterine devices (IUD), including insertion and removal;
    b. Barrier methods including: male and female condoms (Rx required from *provider*, limited to 30 per month), diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, and spermicide alone;
    c. Oral contraceptives including the pill (combined pill and extended/continuous use), and the mini pill (Progestin only), patch;
    d. Other hormonal contraceptives, including inserted and implanted contraceptive devices, hormone contraceptive injections, and the vaginal contraceptive ring;
    e. Emergency contraception (the morning after pill);
    f. FDA-approved tubal ligation; and
    g. For *prescription drug* contraceptives.
6. Vasectomy and services related to this procedure.

Home Health Care Service Expense Benefits
Covered service and supply expenses for *home health care* include, but are not limited to, the following charges:
1. Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
2. Medical/Social Services.
3. *Diagnostic Services*.
4. Nutritional Guidance.
5. *Home Health Aide Services*. The *member* must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the home health care provider. Other organizations may provide services only when *approved* by *us*, and their duties must be assigned and supervised by a professional nurse on the staff of the home health care provider.
6. Therapy services (except for *manipulation therapy* which will not be covered when rendered in the home). Home care visit limits specified in the *Schedule of Benefits* for home care services apply when therapy services are rendered in the home.
7. Medical/Surgical Supplies.
8. *Durable Medical Equipment*.
9. *Prescription Drugs* (only if provided and billed by a home health care agency).
10. Private Duty Nursing.
11. Sleep Studies.

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.

Home infusion therapy will be paid only if *you* obtain prior approval from *our* home infusion therapy administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, *durable medical equipment*, and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes, but is not limited to: injections (intra-muscular, subcutaneous, and continuous subcutaneous), Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain management, and *chemotherapy*.

Exclusions and Limitations:
No benefits will be payable for charges related to *respite care*, *custodial care*, or educational care, under the Home Health Care Service Expense benefit. Non *covered services* and supplies include, but are not limited to:
1. Food, housing, homemaker services, and home delivered meals.
2. Home or outpatient hemodialysis services (these are covered under Therapy Services).
3. *Physician* charges.

4. Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices).
5. Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting home health care provider.
6. Services provided by a member of the patient's *immediate family*.
7. Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside.

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

Hospice Care Service Expense Benefits
Hospice care may be provided in the home or at a *hospice* facility where medical, social, and psychological services are given to help treat patients with a terminal illness. *Hospice* services include routine home care, continuous home care, inpatient *hospice,* and inpatient respite. To be eligible for *hospice* benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending *physician*. *Covered services* will continue if the *member* lives longer than six months.

When *approved* by *your physician*, *covered services* and supplies include the following:
- Skilled nursing services (by an R.N. or L.P.N.).
- *Diagnostic services*.
- Physical, speech and *inhalation therapies* if part of a treatment plan.
- Medical supplies, equipment, and appliances (benefits will not be covered for equipment when the *member* is in a facility that should provide such equipment).
- Counseling services.
- Inpatient confinement at a *hospice*.
- *Prescription drugs* given by the *hospice*.
- Home health aide.

Non *covered services* include but are not limited to:
- Services provided by volunteers.
- Housekeeping 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. The following are not *hospital* confinement under this policy: confinement 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.
2. Daily room and board and nursing services while confined in an *intensive care unit*.
3. Inpatient use of an operating, treatment, or recovery room.
4. Outpatient use of an operating, treatment, or recovery room for *surgery*.
5. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are inpatients.
6. Emergency treatment of an *injury* or *illness*, even if confinement is not required. See *your Schedule of Benefits* for limitations.

Infertility
Covered service expenses under this benefit are provided for *medically necessary* diagnostic and exploratory procedures to determine infertility including surgical procedures to correct a medically diagnosed disease or condition of the reproductive organs including but not limited to treatment of the following:
- Endometriosis;

- Collapsed/clogged fallopian tubes; or
- Testicular failure.

This benefit is subject to *deductible* and *coinsurance*/*copayment*.

No benefits will be payable for charges related to in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT).

Mammography Screening
Covered service expenses under this benefit are provided for two screening mammography views per breast to detect breast cancer in *members*. A screening mammography means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in an asymptomatic *member* and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. Coverage also includes the professional interpretation of film.

Coverage includes:

a. If a *member* is at least thirty-five years of age but under forty years of age, one screening mammography;
b. If a *member* is at least forty years of age but under fifty years of age, either of the following:
    i. One screening mammography every two years; or
    ii. If a licensed *physician* has determined that the *member* has risk factors to breast cancer, one screening mammography every year.
c. If a *member* is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

Mastectomy Benefits
Covered service expenses for a mastectomy include reconstruction of the breast on which the mastectomy has been performed; *surgery* and reconstruction of the other breast to produce a symmetrical appearance and prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Maternity Coverage
Maternity coverage include *inpatient services*, *outpatient services*, and *physician* home visits and office services. These services are used for normal or complicated *pregnancy*, miscarriage, therapeutic abortion (abortion recommended by a *provider*), and ordinary routine nursery care for a healthy newborn. Abortion means the ending of a *pregnancy* before the birth of the infant. Miscarriage is a spontaneous abortion (occurs naturally and suddenly). A therapeutic abortion is one performed to save the life or health of the *member*, or as a result of incest or rape.

Coverage for the inpatient postpartum stay for *you* and *your* newborn child in a *hospital* will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care.

When a decision is made to discharge a *member* or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to all follow-up care that is provided within seventy-two hours after discharge.

Physician-directed or advanced practice registered nurse-directed follow-up care after delivery is also covered. Services covered as follow-up care include physical assessment of the *member* and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any *medically necessary* and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent

pediatric, obstetric, and nursing professionals. The coverage applies to services provided in a medical setting or through *home health care* visits. The coverage shall apply to a *home health care* visit only if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if *your* attending *physician* or a certified nurse-midwife, if attending the *member* in collaboration with a *physician*, determines further inpatient postpartum care is not necessary for *you* or *your* newborn child, provided the following are met and the *member* concurs:

- In the opinion of *your* attending *physician*, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
    1. the antepartum, intrapartum, and postpartum course of the *member* and infant;
    2. the gestational stage, birth weight, and clinical condition of the infant;
    3. the demonstrated ability of the *member* to care for the infant after discharge; and
    4. the availability of post discharge follow-up to verify the condition of the infant after discharge.

Covered services include at-home post delivery care visits at *your residence* by a *physician* or nurse performed no later than 72 hours following *you* and *your* newborn child's discharge from the *hospital*. Coverage for this visit includes, but is not limited to:

1. parent education;
2. assistance and training in breast or bottle feeding; and
3. performance of any maternal or neonatal tests routinely performed during the usual course of inpatient care for *you* or *your* newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At *your* discretion, this visit may occur at the *physician's* office.

Newborns' and Mothers' Health Protection Act Statement of Rights
If services provided or expenses incurred 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.

Medical Foods
We cover medical foods and formulas for outpatient total parenteral nutritional therapy; outpatient elemental formulas for malabsorption; and dietary formula when *medically necessary* for the treatment of Phenylketonuria (PKU) and inborn errors of metabolism.

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

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 Ambetter. Mental health services will be provided on an *inpatient* and *outpatient* basis and include treatable mental health conditions. These conditions 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 and do not need a referral from *your PCP* in order to initiate treatment. *Deductible amounts*, *copayment* or *coinsurance* amounts and treatment limits for covered mental health and *substance use disorder* benefits will be applied in the same manner as physical health service benefits.

Covered services for mental health and *substance use disorder* are included on a non-discriminatory basis for all *members* for the diagnosis and treatment of mental, emotional, and/or *substance use 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 recent edition of the International Classification of Diseases and Related Health Problems (ICD).

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 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. Individual and group mental health evaluation and treatment;
4. *Outpatient services* for the purpose of monitoring drug therapy;
5. Outpatient detoxification programs;
6. Diagnostic and treatment services for biologically based mental illnesses;
7. Psychological and Neuropsychological testing and assessment;
8. Medication management services;
9. *Applied behavioral analysis*;
10. *Telehealth;*
11. Outpatient *rehabilitation* treatment;

12. Mental health day treatment; and
13. 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 *Schedule of Benefits* for more information regarding services that require *prior authorization* and specific benefit, day or visit limits, if any.

Medical and Surgical Expense Benefits

Medical *covered service expenses* include, but are not limited to, charges:

1. For *surgery* in a *physician's* office or at an *outpatient surgical facility*, including services and supplies.
2. Made by a *physician* for professional services, including *surgery*.
3. Made by an assistant surgeon.
4. For the professional services of a *medical practitioner*.
5. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies*.
6. For *diagnostic services* using radiologic, ultrasonographic, or laboratory services.
7. For *chemotherapy* (including *oral chemotherapy*) and *radiation therapy* or treatment.
8. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
9. For the cost and administration of an anesthetic.
10. For oxygen and its administration.
11. For *surgery*, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint**.**
12. For reconstructive breast *surgery* charges as a result of a partial or total mastectomy for breast cancer.
13. For routine patient care for patients enrolled in an *eligible cancer clinical trial*.
14. For the following types of tissue transplants:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.
    e. Implantable prosthetic lenses, in connection with cataracts.
15. 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.
16. Allergy testing, injections, and serum.
17. X-ray and other radiology services.
18. Magnetic Resonance Imaging (MRI).
19. CAT scans.
20. Positron emission tomography (PET scanning).
21. For routine care costs that are incurred in the course of a clinical trial that is deemed an *experimental* or *investigational treatment* if the services provided are otherwise considered *covered services* under the policy.
22. Cytologic screenings for cervical cancer.
23. Cochlear Implants.
24. Vision correction as a result of *surgery* or accident.
25. *Medically necessary telehealth services* subject to the same clinical and *utilization review* criteria, plan requirements, limitations, and *cost sharing* as the same health care services when delivered to an insured in person.

When available in *your* area, *your* coverage will include online visit services. *Covered services* include a medical consultation using the internet via a webcam, chat, or voice. Non *covered services* include, but are not limited to, communications used for:

- Reporting normal lab or other test results;
- Office appointment requests;
- Billing, insurance coverage, or payment questions;
- Requests for referrals to doctors outside the online care panel;
- Benefit precertification; or
- *Physician* to *physician* consultation.

Medically Necessary Vision Services

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

Excluded services for routine and non-routine vision include:

- Visual Therapy.
- Any vision services, treatment, or materials not specifically listed as a *covered service*.
- Low vision services and hardware for adults.
- Non-network care, except when *authorized*.

Non-Routine Dental Services

Coverage for non-routine *dental services* for specified conditions is limited to the following:

1. Facility charges for *outpatient services* for the removal of teeth or for other dental processes if the patients' medical condition or the dental procedure requires a *hospital* setting to ensure the safety of the patient; or
2. *Dental services* for any of the following:
    a. Transplant preparation.
    b. Initiation of immunosuppressive.
    c. Direct treatment of acute traumatic *injury*, cancer, or cleft palate.

Prescription Drug Expense Benefits

Covered service expenses in this benefit subsection include charges from a licensed *pharmacy* for:

1. A *prescription drug*, including for the treatment of biologically based mental illnesses on the same terms and conditions as any other disease or disorder.
2. Prescribed, self-administered, anticancer medication.
3. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician*.
4. Off-label drugs.

Our drug formulary includes the list of drugs that *our* Pharmacy and Therapeutics Committee (PTC) has approved for *our members*. The purpose of the PTC is to review and make decisions for changes to the drugs listed for coverage, the edits related to controls or limitations of drug coverage, and the policies and procedures governing provision of drug coverage under the formularies. *Our* Pharmacy and Therapeutics Committee, which is primarily composed of practicing physicians, selects drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature. The Pharmacy and Therapeutics Committee meets at least quarterly to consider additions and deletions based on new information or drugs that become available.

See the *Schedule of Benefits* for benefit levels.

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

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

Off-label drugs are:

a. Recognized for treatment of the indication in at least one (1) standard reference compendium; or
b. The drug is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

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

Non-Formulary and Tiered Formulary Contraceptives:
Under *Affordable Care Act*, *you* have the right to obtain contraceptives that are not listed on the formulary (otherwise known as "non-formulary drugs") and tiered contraceptives (those found on a formulary tier other than "Tier 0 – no cost share") at no cost to *you* on *your* or *your medical practitioner's* request. To exercise this right, please get in touch with *your medical practitioner*. *You* can utilize the usual *prior authorization* request process. See "Prior Authorization" below for additional details.

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

Drug Discount, Coupon or Copay Card:
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*.

Prescription Drug Exception Process

1. 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. 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 be granted, *we* will provide coverage of the non-formulary drug for the duration of the prescription, including refills.

2. 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 *member's* life, health, or ability to regain maximum function or when a *member* is undergoing a current course of treatment using a non-formulary drug. Within 24 hours of the request being received, *we* will provide the *member*, the *member's* designee, or the *member's* prescribing *physician* with *our* coverage determination. Should the expedited exception request be granted, *we* will provide coverage of the non-formulary drug for the duration of the exigency.

3. 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 *independent review organization* (*IRO*).

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*.

For a prior approval related to a chronic condition, the *approval* for an approved drug will be honored for the lesser of 12 months or the last day of the *covered person's* enrollment under the policy.

Opioid Analgesics Approval Process
Initial Approval Criteria
For Short Term Therapy – *prior authorization* will not be required for opioid use meeting all of the following requirements:

1. *Member* has received less than 28 day supply of opioid in the last 90 days;
2. Request if for less than or equal to a 14 day supply;
3. *Member* is on no more than two (2) different opioid analgesics concurrently;
4. Request is for an immediate release opioid; and
5. Total opioid dose does not exceed 80 morphine milligram equivalents (MME)/day.

For Cancer or Palliative Care – for hospice patient or in hospice care program or diagnosed with a terminal condition, but not a hospice patient:

1. Prescribed for pain associated with cancer or palliative care;
2. For request for more than two (2) agents concurrently, prescriber must submit a documented clinical rationale supporting that the addition of an extended release agent and the upward titration of existing opioid analgesics is inappropriate or contraindicated; and
3. Request does not exceed *our* quantity limit.

Please note the approval duration is for 12 months.

For Chronic Pain – Long Term Therapy:

1. *Member* must be diagnosed with chronic pain;
2. *Member* has received more than or equal to a 28 day supply of opioid within a 90 day period;
3. If request is for an extended release agent, a documented failure of an immediate release opioid has occurred;
4. *Member* meets one of the following:
   a. Failure of at least two (2) non-opioid ancillary treatments (such as a non-steroidal anti-inflammatory drugs (NSAIDs), acetaminophen, anticonvulsants, antidepressants, etc.) unless contraindicated or clinically significant adverse effect are experienced; or
   b. *Member* has had a total of 84 cumulative days of opioid therapy in the last 120 days;
5. *Member* will be maintained on no more than two (2) opioid analgesics concurrently (If *member* requires therapy with two opioid analgesics, regimen must consist of one immediate-release and one extended-release analgesic);
6. Total opioid dose does not exceed 80 MME/day;
7. *Provider* agrees to continuously assess the *member's* pain management regimen for possible discontinuation of opioid therapy; and
8. Documentation that the *provider* has reviewed the Ohio Guidelines for Prescribing Opioids for the Treatment of Chronic, Non-terminal Pain 80mg of a Morphine Equivalent Daily Dose (MED) "Trigger Point".

Please note the approval duration is for 3 months.

Continued Therapy

Cancer or Palliative Care:

1. Prescribed for pain associated with cancer or palliative care;
2. If *member* is receiving more than two (2) opioid analgesics concurrently, at least one (1) of the following requirements has been met:
    a. Prescriber previously provided a documented clinical rationale for the use of more than two (2) opioid analgesics concurrently; or
    b. Prescriber provides a documented clinical rational supporting that addition of an extended release agent or upward titration of existing opioid analgesics is inappropriate or contraindicated; and
3. Request does not exceed *our* quantity limit.

Please note the approval duration is for 12 months.

Chronic Pain – Long Term Therapy:

1. *Member* has previously met all initial approval criteria for long-term opioid use;
2. Prescriber provides documentation supporting inability to discontinue opioid therapy;
3. *Member* will not be maintained on more than two (2) opioid analgesics concurrently (If *member* requires therapy with two opioid analgesics, regimen must consist of one immediate-release and one extended-release analgesic);
4. Total opioid dose should not exceed 80 MME/day; and
5. Documentation that the *provider* has reviewed the Ohio Guidelines for Prescribing Opioids for the Treatment of Chronic, Non-terminal Pain 80mg of a Morphine Equivalent Daily Dose (MED) "Trigger Point".

Please note the approval duration is for 3 months.

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*, blood, or blood plasma unless listed on the formulary.
3. For medication that is to be taken by the *member*, in whole or in part, at the place where it is dispensed.
4. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
5. For a refill dispensed more than 12 months from the date of a *physician's* order.
6. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
7. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary or those which *we* must cover under Federal law with a *prescription order*.
8. For drugs labeled "Caution - limited by federal law to investigational use" or for *investigational* or *experimental* drugs.
9. For more than a 31-day supply when dispensed in any one prescription or refill, or for maintenance drugs, up to 90-day supply when dispensed by mail order or a pharmacy that participated in extended day supply network.
10. For any drug that *we* identify as therapeutic duplication through the Drug Utilization Review program.
11. 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.

12. Foreign prescription medications, except those associated with an *emergency medical condition* while *you* are travelling 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.
13. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
14. 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.
15. Medications used for cosmetic purposes.

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.

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) in glass or plastic, or initial supply of *medically necessary* contacts every calendar year;
    a. Other lens options included are: Fashion and Gradient Tinting, Ultraviolet Protective Coating, Oversized and Glass-Grey #3 Prescription Sunglass lenses, Polycarbonate lenses, Blended Segment lenses, Intermediate Vision lenses, Standard Progressives, Premium Progressives (Varilux®, etc.), Photochromic Glass Lenses, Plastic Photosensitive Lenses (Transitions®), Polarized Lenses, Standard Anti-Reflective (AR) Coating, Premium AR Coating, Ultra AR Coating, and Hi-Index Lenses.
3. One pair of prescription frames every calendar year; and
4. Low vision optical devices including low vision services, and an aid allowance with follow-up care once *prior authorization* has been received.

Covered service and supply expenses do not include:

1. Visual therapy;
2. Two pair of glasses as a substitute for bifocals;
3. Replacement of lost or stolen eyewear; or
4. Out of network care, except where *prior 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 in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.
5. 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 *deductibles*, *cost sharing percentage* provisions, and *copayment amounts* under the *contract* when the services are provided by a *network provider*. If a service is considered diagnostic or non-preventive, *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.

Benefits for *covered 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 *deductibles*, *coinsurance* provisions, or *copayment amounts* to services when a *covered person* chooses not to use a high value service that is otherwise exempt from *deductibles*, *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.

Covered Preventive Services for Adults include:

1. Abdominal Aortic Aneurysm one-time screening for adults of specified ages who have ever smoked;
2. Alcohol misuse screening and counseling;
3. Aspirin use to prevent cardiovascular disease for adults of certain ages;
4. Blood pressure screening for all adults;
5. Cholesterol screening for adults of certain ages or at higher risk;
6. Colorectal Cancer screening for adults over 50;
7. Depression screening for adults;
8. Type 2 Diabetes screening for adults with high blood pressure;
9. Diet counseling for adults at higher risk for chronic disease;
10. Hepatitis B screening for adults at high risk, including adults from countries with 2% or more Hepatitis B prevalence, and U.S.-born adults not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence;
11. Hepatitis C screening for adults at increased risk, and one time for everyone born 1945-1965;
12. HIV screening for all adults at higher risk;
13. Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
    - Diphtheria;
    - Hepatitis A;
    - Hepatitis B;
    - Herpes Zoster;
    - Human Papillomavirus;
    - Influenza (Flu Shot);
    - Measles, Mumps, Rubella;
    - Meningococcal;
    - Pneumococcal;
    - Tetanus, Diphtheria, Pertussis; and
    - Varicella.

14. Lung cancer screening for adults 55-80 at high risk for lung cancer because the adult is a heavy smoker or has quit in the past 15 years;
15. Obesity screening and counseling for all adults;
16. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;
17. Tobacco use screening for all adults and cessation interventions for tobacco users; and
18. Syphilis screening for all adults at higher risk.

Covered Preventive Services for Women and Pregnant Women include:

1. Anemia screening on a routine basis for pregnant *member*;
2. Urinary tract or other infection screening for pregnant *member*;
3. BRCA counseling about genetic testing for *members* at higher risk;
4. One cytologic screening per year or more often if recommended by a *physician*;
5. A baseline mammogram for *members* 35 to 39 years of age. Breast Cancer Mammography screenings every 1 to 2 years for *members* over 40. A mammogram at the age and intervals considered *medically necessary* by the *member's* health care provider for a *member* under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors;
6. Breast Cancer Chemoprevention counseling for *members* at higher risk;
7. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing *members*;
8. Cervical Cancer screening for sexually active *members*;
9. Chlamydia Infection screening for younger *members* and other *members* at higher risk;
10. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for *members* with reproductive capacity (not including abortifacient drugs);
11. Domestic and interpersonal violence screening and counseling for all *members*;
12. Folic Acid supplements for *members* who may become pregnant;
13. Gestational diabetes screening for *members* 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
14. Gonorrhea screening for all *members* at higher risk;
15. Hepatitis B screening for pregnant *members* at their first prenatal visit;
16. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active *members*;
17. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for *members* with normal cytology results who are 30 or older;
18. Coverage for *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis;
19. Rh Incompatibility screening for all pregnant *members* and follow-up testing for *members* at higher risk;
20. Tobacco use screening and interventions for all *members*, and expanded counseling for pregnant tobacco users;
21. Sexually Transmitted Infections (STI) counseling for sexually active *members*;
22. Syphilis screening for all pregnant *members* or other *members* at increased risk; and
23. Well-*member* visits to obtain recommended preventive services.

Covered Preventive Services for Children include:

1. Alcohol and drug use assessments for adolescents;
2. Autism screening for children at 18 and 24 months;
3. Behavioral assessments for children of all ages. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
4. Blood pressure screening for children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
5. Cervical Dysplasia screening for sexually active adolescents;
6. Congenital Hypothyroidism screening for newborns;
7. Depression screening for adolescents;

8. Developmental screening for children under age 3, and surveillance throughout childhood;
9. Dyslipidemia screening for children at higher risk of lipid disorders. Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
10. Fluoride Chemoprevention supplements for children without fluoride in their water source;
11. Gonorrhea preventive medication for the eyes of all newborns;
12. Hearing screening for all newborns;
13. Height, weight, and Body Mass Index measurements for children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
14. Hematocrit or Hemoglobin screening for children;
15. Hemoglobinopathies or sickle cell screening for newborns;
16. Hepatitis B screening for adolescents at high risk, including adolescents from countries with 2% or more Hepatitis B prevalence, and U.S.-born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence: 11-17 years;
17. HIV screening for adolescents at higher risk;
18. Hypothyroidism screening for newborns;
19. Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis;
    - Haemophilus influenzae type b;
    - Hepatitis A;
    - Hepatitis B;
    - Human Papillomavirus;
    - Inactivated Poliovirus;
    - Influenza (Flu Shot);
    - Measles, Mumps, Rubella;
    - Meningococcal;
    - Pneumococcal;
    - Rotavirus; and
    - Varicella.
20. Iron supplements for children ages 6 to 12 months at risk for anemia;
21. Lead screening for children at risk of exposure;
22. Medical history for all children throughout development. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
23. Obesity screening and counseling;
24. Oral health risk assessment for young children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years;
25. Phenylketonuria (PKU) screening for this genetic disorder in newborns;
26. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
27. Tuberculin testing for children at higher risk of tuberculosis. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years; and
28. Vision screening for all children.

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.

Notification
As required by PHS Act section 2715(d)(4), *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 1-877-687-1189 (TTY/TDD 1-877-941-9236) 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.BuckeyeHealthPlan.com.

You may also access the Federal Government's website at www.healthcare.gov/coverage/preventive-care-benefits/ to obtain current information.

Rehabilitation, Habilitation, and Skilled Nursing Facility Expense Benefits
A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the *member's* ability to function as independently as possible; including skilled rehabilitative nursing care, *physical therapy*, *occupational therapy*, *speech therapy*, and services of a social worker or psychologist. The goal is to obtain practical improvement, or maintain the member's abilities, in a reasonable length of time in the appropriate inpatient setting.

Covered service expenses include services provided or expenses incurred for *rehabilitation* services (including *cardiac rehabilitation*) or confinement in a *skilled nursing facility*, subject to the following limitations:

1. *Covered service expenses* available to a *member* while confined primarily to receive *rehabilitation* are limited to those specified in this provision.
2. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *skilled nursing facility* for:
    a. Daily room and board and nursing services.
    b. *Diagnostic services*.
    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.
3. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners*.

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*.

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

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

Covered service expenses shall be provided for *medically necessary habilitation* services, including, but not limited to:

1. *Habilitation* services to children ages 0 to 21 with a medical diagnosis of *autism spectrum disorder*, which at a minimum shall include:
    a. Out-patient physical *habilitation* services including speech and language therapy and/or *occupational therapy*, performed by a licensed therapist. Clinical therapeutic intervention defined as therapies supported by empirical evidence, which include, but are not limited to, *applied behavioral analysis*, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the services in accordance with a treatment plan. Mental/behavioral health *outpatient services* performed by a licensed psychologist, psychiatrist, or *physician* to provide consultation, assessment, development, and oversight of treatment plans.

Exclusions:
Non-*covered services* for physical medicine and *rehabilitation* include, but are not limited to:

1. Admission to a *hospital* mainly for *physical therapy*; or
2. Long term *rehabilitation* in an inpatient setting.

Limitations:
See the *Schedule of Benefits* for benefit levels or additional limits.

Respite Care Expense Benefits
Respite care is covered on an inpatien*t* or outpatient basis to allow temporary relief to family members from the duties of caring for a *covered person*. Respite days that are applied toward the *deductible* are considered benefits provided and shall apply against any maximum benefit limit for these services. Respite care coverage is limited to 14 days per calendar year.

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
Covered Services For Transplant Service Expenses:
Transplants are a covered benefit when *prior authorized* in accordance with this *contract*. Transplant services must be provided by a contracted *provider* and facility, and meet other medical criteria as set by Medical Management Policy.

If *we* determine that a *member* is an appropriate candidate for a *medically necessary* transplant, medical service expense 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 approved as a *medically necessary* transplant.

Transplant benefit expenses are limited to $10,000 for transportation and lodging per transplant, and $30,000 for donor search per transplant.

Ancillary "Center Of Excellence" Service Benefits:
A *member* may obtain services in connection with a transplant from any *physician*. However, if a transplant is performed in a *Center of Excellence*, *covered service expenses* for the 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 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. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (USFDA) regulation, regardless of whether the trial is subject to USFDA oversight.
9. Child care.
10. Mileage within the medical transplant facility city.
11. Rental cars, buses, taxis, or shuttle service, except as specifically *approved* by *us*.
12. Frequent Flyer miles.
13. Coupons, vouchers, or travel tickets.
14. Prepayments or deposits.
15. Services for a condition that is not directly related, or a direct result, of the transplant.
16. Telephone calls.
17. Laundry.
18. Postage.
19. Entertainment.
20. Interim visits to a medical care facility while waiting for the actual transplant procedure.
21. Travel expenses for donor companion/caregiver.
22. Return visits for the donor for a treatment of a condition found during the evaluation.

Vision Expense Benefits
Routine Vision Adult 19 years of age or older
Routine eye exams, prescriptions eyeglasses, and standard contact lenses are covered and are managed through *your* vision vendor. For information regarding *your* specific *copayments* and/or *deductible* 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, have *your* participating *provider* 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 1-877-687-1189 (TTY/TDD 1-877-941-9236).

Health Management Programs Offered
Ambetter from Buckeye Health Plan 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.BuckeyeHealthPlan.com or by contacting Member Services at 1-877-687-1189 (TTY/TDD 1-877-941-9236).

Prior Authorization

Prior Authorization Required

Some *covered service expenses* require *prior authorization*. In general, it is *your* responsibility to ensure that *your network provider* obtains *authorization* from *us* prior to the *network provider* providing a service or supply to *you* or *your dependent member*.

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

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

Prior Authorization requests must be received by phone/efax/Provider portal as follows:

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

After *prior authorization* has been requested, *we* will notify *you* and *your provider* if the request has been *approved* or denied as follows:

1. For *urgent care services*, within 48 hours of receipt of the request.
2. For urgent concurrent review within 24 hours of receipt of the request.
3. For non-urgent pre-service requests within 10 days of receipt of the request.
4. For post-service requests, within 30 days of receipt of the request.

As used in this section, **urgent care service** means a medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:

1. Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or
2. In the opinion of a *physician* with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

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

How to Obtain Prior Authorization

It is *your* responsibility to obtain *prior authorization* or to confirm that a *network provider* has obtained *prior authorization* on *your* behalf. Contact *us* by telephone at 1-877-687-1189 (TTY/TDD 1-877-941-9236) before the service or supply is provided to *you*.

Electronic Procedure

Providers will have access to prior authorization forms through the provider portal that can be submitted to us and accepted for review through the same portal. *We* will provide an electronic receipt to the *provider* confirming receipt of the prior authorization request. If *we* request additional information, the *provider* must provide acknowledgement of the request for additional information to *us*.

If there is an operational difficulty, such as limited internet connectivity, or a financial hardship that prevents the *provider* from utilizing the electronic procedure, the *provider* may contact *us* to develop an appropriate process for receiving prior authorization requests.

Failure to Obtain Prior Authorization
Failure to comply with the *prior authorization* requirements will result in benefits being denied. If *you* disagree with *our* decision, *you* may appeal pursuant to the Internal Claims and Appeals Procedures and External Review section.

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.

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

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*. *We* will not retroactively deny *prior authorizations* as long as the *authorization* was obtained based on complete and accurate submission of all necessary information relative to an eligible *member* and the *provider* renders services in good faith and pursuant to the *authorization* and all of the terms and conditions of the *provider's contract* with *us*.

Services from Non-Network Providers
Except for emergency medical services, *covered services* from *non-network providers* will not be covered. If required *medically necessary* services are not available from *network providers*, ***you*** **or the** ***network provider*** **must request** ***prior authorization*** **from** ***us*** **before** ***you*** **may receive services from** ***non-network providers***. Otherwise *you* will be responsible for all charges incurred.

Appeal of Prior Authorization Denial
Prior Authorization denials for *urgent care* will be considered within 48 hours after receipt of the appeal and for non-*urgent care* within 10 days of receipt of the appeal. The appeal will be between the *provider* requesting the service in question and a clinical peer. If the appeal does not resolve the disagreement, either the *member* or the *member's authorized representative* may request an external review. Please refer to the Internal Claims and Appeals Procedures and External Review section for additional details.

Concurrent Care Decision information can be found in the Internal Claims and Appeals Procedures and External Review section.

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. Any services performed for a *member* by a *member's immediate family*.
3. 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*, except as expressly provided for under the Benefits After Coverage Terminates clause in this policy's Termination section.
2. For any portion of the charges that are in excess of the *eligible service expense*.
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*.
4. For cosmetic breast reduction or augmentation, except for the *medically necessary* treatment of Gender Dysphoria.
5. For the reversal of sterilization and vasectomies.
6. For non-therapeutic abortion.
7. For expenses for television, telephone, or expenses for other persons.
8. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
9. For telephone consultations, except those meeting the definition of *telehealth services*, or for failure to keep a scheduled appointment.
10. 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 Expense Benefits.
11. For *cosmetic treatment*, except for *medically necessary reconstructive surgery* that is incidental to or follows *surgery* or an *injury* or is performed to correct a birth defect.
12. For diagnosis or treatment of learning disabilities.
13. For diagnosis or treatment of nicotine addiction, except as expressly provided for under Preventive Care Expense Benefits.
14. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
15. While confined primarily to receive *rehabilitation*, *custodial care*, educational care, or nursing services (unless expressly provided for in this *contract*).
16. For vocational or recreational therapy, vocational *rehabilitation*, outpatient *speech therapy*, or *occupational therapy*, except as expressly provided for in this *contract*.
17. 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.
18. For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
19. 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.

20. For treatment received outside the United States, except for a medical emergency while traveling for up to a maximum of 90 consecutive days.
21. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *member* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *member's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *member's 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.
22. For any services or supplies provided to a person not covered under the contract related to surrogate parenting or surrogate pregnancy, including, but not limited to, the bearing of a child by another person for an infertile couple.
23. For or related to treatment of hyperhidrosis (excessive sweating).
24. For fetal reduction surgery.
25. 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.
26. 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.
27. For the following miscellaneous items: artificial insemination (except where required by federal or state law); biofeedback; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; 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; smoking cessation drugs, programs, or services, except as provided for under Preventive Care Expense Benefits section; transportation expenses, unless specifically described in this *contract*.
28. For court ordered testing or care unless *medically necessary*.
29. 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.
30. Services or care provided or billed by a school, custodial care center for the developmentally disabled.
31. Bariatric surgery.
32. For diagnostic testing, laboratory procedures, screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment. This exclusion does not apply to preventive services.
33. Biofeedback.

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 *you* are no longer eligible for coverage --- the last day of coverage is the last day of the month following the month in which the notice is sent by *us* unless *you* request an earlier termination effective date;
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; or
4. *You* obtain other minimum essential coverage.

Refund upon Cancellation

We will refund any premium paid and not earned due to *contract* termination. *You* may cancel the *contract* at any time by written notice, delivered or mailed, to the Marketplace, or if an off-exchange *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 Commissioner 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.

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.

Right of Reimbursement

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

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

However, if payment by or for the *third party* has not been made by the time *we* receive acceptable *proof of loss*, *we* will pay regular *contract* benefits, as outlined in *our* Claims section and pursuant to the Ohio Prompt Payment Law, for the *member's loss*. By accepting benefits under this *contract*, the *member* specifically acknowledges *our* right of reimbursement. This right of reimbursement attaches when *we* have provided health care benefits for expenses incurred due to *third party injuries* and the *member's* or the *member's* representative has recovered any amounts from any source. *We* will have the right to be reimbursed to the extent permitted by Ohio law of benefits *we* provided or paid for the *illness* or *injury* if the *member* subsequently receives any payment from any *third party*. The *member* (or the guardian, legal representatives, estate, or heirs of the *member*) shall promptly reimburse *us* from the settlement, judgment, or any payment received from any *third party*. These sources include, but are not limited to:

- Payments made by a *third party* or any insurance company on behalf of the *third party*;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises, or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate a *member* for *injuries* caused by a *third party*.

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

1. To fully cooperate with *us* in order to obtain information about the *loss* and its cause.
2. To immediately inform *us* in writing of any claim made or lawsuit filed on behalf of a *member* in connection with the *loss*.
3. To include the amount of benefits paid by *us* on behalf of a *member* in any claim made against any *third party*.
4. That *we*:
    a. Will have a lien on all money received by a *member* in connection with the *loss* to the extent permitted by Ohio law.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.

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

We will not pay attorney fees or costs associated with the *member's* claim or lawsuit unless *we* previously agreed in writing to do so.

If a dispute arises as to the amount a *member* must reimburse *us*, the *member* (or the guardian, legal representatives, estate, or heirs of the *member*) agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by *us* until the dispute is resolved. Additionally, either party may file an action pursuant to Ohio law to resolve any issue related to the distribution of any money recovered from the

third party.

However, if less than the full value of the *loss* is recovered because of comparative negligence, diminishment due to a party's liability pursuant to Ohio law, or by reason of the collectability of the full value of the claim for *injury*, death, or loss to person resulting from limited liability insurance or any other cause, *our* reimbursement amount shall decrease in the same proportion as the *member's* interest.

Coordination of Benefits

The Coordination of Benefits (COB) provision applies when you have healthcare coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its *contract* terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100 percent of the total Allowable Expense.

Definitions
For the purpose of this Section, the following definitions shall apply:

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

   1. Plan includes: Group and nongroup insurance contracts; Health insuring corporation (HIC) contracts; Coverage under group or nongroup closed panel plans (whether insured or uninsured); Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan as permitted by law.

   2. Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; Accident only coverage; Specified disease or specified accident coverage; Supplemental coverage as described in Revised Cody sections 3923.37 and 1751.56; School accident-type coverage; Non-medical components of long term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each *contract* for coverage under 1 and 2 above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision the part of the *Contract* providing the healthcare benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the *Contract* providing healthcare benefits is separate from this Plan. A *contract* may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when you have healthcare coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. Allowable Expense is a healthcare expense, including *deductibles*, *coinsurance* and *copayments*, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable Expense. The following are examples of expenses that are not Allowable Expenses:

1. The difference between the cost of a semi-private *hospital* room and a private *hospital* room is not an Allowable Expense, unless one of the Plans provides coverage for private *hospital* room expenses.
2. If *you* are covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If *you* are covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If *you* are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's *contract* permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
5. The amount of any benefit reduction by the Primary plan because *you* have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
6. When Medicare is the Primary Plan, Medicare's allowable amount is the allowable expense.

E. Closed Panel Plan is a Plan that provides healthcare benefits to *you* primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When *you* are covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the *contract* holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1.) **Non-Dependent or Dependent**.
The Plan that covers *you* other than as a dependent, (for example as an employee, member, policyholder, subscriber, or retiree) is the Primary Plan and the Plan that covers *you* as a dependent is the Secondary Plan. However, if *you* are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering *you* as a dependent, and primary to the Plan covering *you* as other than a dependent, then the order of benefits between the two plans is reversed so that the

plan covering *you* as an employee, member, policyholder, subscriber, or retiree is the Secondary Plan and the other plan is the Primary Plan.

2.) **Dependent Child Covered Under More Than One Plan.**
Unless there is a court decree stating otherwise, when a child is covered by more than one Plan the order of benefits is determined as follows:

a. For a child whose parents are married or are living together, whether or not they have ever been married:
   - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
   - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
   - However, if one spouse's Plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), *we* will follow the rules of that Plan.

b. For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   i. If a court decree states that one of the parents is responsible for the child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   ii. If a court decree states that both parents are responsible for the child's healthcare expenses or healthcare coverage, the provisions of paragraph a. above shall determine the order of benefits;
   iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the child, the provisions of paragraph a. above determine the order of benefits; or
   iv. If there is no court decree allocating responsibility for the child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
      - The Plan covering the Custodial Parent, first;
      - The Plan covering the spouse of the Custodial Parent, second;
      - The Plan covering the noncustodial parent, third; and then
      - The Plan covering the spouse of the noncustodial parent, last.

c. For a child covered under more than one Plan of individuals who are not the parents of the child, the provisions of paragraph a. or b. above shall determine the order of benefits as if those individuals were the parents of the child.

3.) **Active Employee or Retired or Laid-off Employee**
The Plan that covers *you* as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering *you* as a retired or laid-off employee is the Secondary Plan. The same would hold true if *you* are a dependent of an active employee and *you* are a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

4.) **COBRA or State Continuation Coverage**
If *you* have coverage provided under COBRA or under a right of continuation provided by state or other federal law and *you* are also covered under another Plan, the Plan covering *you* as an employee, member, subscriber, or retiree or covering *you* as a dependent of an employee, member, subscriber, or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

5.) **Longer or Shorter Length of Coverage**
The Plan that covered *you* as an employee, member, policyholder, subscriber, or retiree longer is the Primary Plan and the Plan that covered *you* the shorter period of time is the Secondary Plan. If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

6.) **If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.**

Effect on the Benefits of This Plan

A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a calendar year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan must calculate the benefits it would have paid in the absence of other healthcare coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other healthcare coverage.
B. If *you* are enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plan.

Right to Receive and Release Needed Information

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other Plans. *We* may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering *you*. *We* need not tell, or get the consent of, any person to do this. To claim benefits under this Plan, *you* must give us any facts *we* need to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this plan. If it does, *we* may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. *We* will not have to pay that amount again. The term “payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by *us* is more than it should have paid under this COB provision, *we* may recover the excess from one or more of the persons *we* have paid or for whom *we* have paid, or any other person or organization that may be responsible for the benefits or services provided for *you*. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If *you* believe that we have not paid a claim properly, *you* should first attempt to resolve the problem by contacting *us* at 1-877-687-1189 (TTY/TDD 1-877-941-9236) or Ambetter.BuckeyeHealthPlan.com. *You* should also refer to the Complaint and Appeals procedures. If *you* are still not satisfied, *you* may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at http://insurance.ohio.gov.

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.

Proof of Loss
We must receive written *proof of loss* within 90 days of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than one year late will not be accepted, unless *you* or *your* covered *dependent member* had no legal capacity to submit such proof during that year. If *we* do accept the *proof of loss* after a year, *we* will then process the *proof of loss* within 90 days.

Cooperation Provision
Each *member*, or other person acting on his or her behalf, must cooperate fully to assist *us* in determining *our* rights and obligations under the *contract*.

Time for Payment of Claims
Benefits will be paid within 30 days after receipt of *proof of loss*. Should *we* determine that additional supporting documentation is required to establish responsibility of payment, *we* shall pay benefits within 45 days after receipt of *proof of loss*. If *we* do not pay within such period, *we* shall pay interest at the rate of 18 percent per annum from the 30th day after receipt of such *proof of loss* to the date of late payment.

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*.

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* and evidence of payment to the *provider*.

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

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

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

Grievance Process
A *grievance* or *complaint* is an expression of dissatisfaction regarding *our* products or services. *You* or *your* designee may submit a *grievance* verbally or in writing. A *grievance* may be filed for issues including quality of care, *physician* behavior, waiting time for services, and involuntary disenrollment. You have up to 180 calendar days to file a *grievance*. The 180 calendar days start on the date of the situation *you* are not satisfied with. Depending on the nature of the *grievance* and whether or not a response is requested, *we* will respond verbally and/or in writing within thirty (30) business days following receipt of the *grievance*, or should a *member's* medical condition necessitate and expedited review a response within 72 hours.

The response will state the reason for *our* decision, and inform the *member* of the right to pursue a further review, and explain the procedures for initiating such review. *Grievances* will be considered when measuring the quality and effectiveness of *our* products and services.

Non-Assignment
The coverage, rights, privileges and benefits provided for under this contract are not assignable by you or anyone acting on your behalf. Any assignment or purported assignment of coverage, rights, privileges and benefits provided for under this contract that you may provide or execute in favor of any hospital, provider, or any other person or entity shall be null and void and shall not impose any obligation on us.

No Third Party Beneficiaries
This 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.

How to Contact Us
Buckeye Community Health Plan

P.O. Box 5010
Farmington, MO 63640-5010
1-877-687-1189 (TTY/TDD 1-877-941-9236), fax 1-866-258-4102, twenty-four hours per day, seven days a week.

Internal Claims and Appeals Procedures and External Review

Overview

If *you* need help: If *you* do not understand *your* rights or if *you* need assistance understanding *your* rights or *you* do not understand some or all of the information in the following provisions, *you* may contact Buckeye Community Health Plan at the Member Services Department, 4349 Easton Way, Suite 300, Columbus, OH, 43219, by telephone at 1-877-687-1189 (TTY/TDD 1-877-941-9236), by fax at 1-877-941-8076 or Ambetter.BuckeyeHealthPlan.com.

Internal Claims and Appeals Procedures: When a health insurance plan denies a claim for a treatment or service (a claim for plan benefits, *you* have already received (*post-service claim* denial) or denies *your* request to *authorize* treatment or service (pre-service denial), *you*, or someone *you* have authorized to speak on *your* behalf (an *authorized representative*), can request an appeal of the plan's decision. If the plan rescinds *your* coverage or denies *your* application for coverage, *you* may also appeal the plan's decision. When the plan receives *your* appeal, it is required to review its *own* decision. When the plan makes a decision, it is required to notify *you* (provide notice of an *adverse benefit determination*) including:

- The reasons for the plan's decision;
- *Your* right to file appeal the decision;
- *Your* right to request an *external review*; and
- The availability of a Consumer Assistance Program at The Ohio Department of Insurance.

- If *you* do not speak English, *you* may be entitled to receive appeals' information in *your* native language upon request.
- When *you* request an *internal appeal*, the plan must give *you* its decision as soon as possible, but no later than:
  - 48 hours after receiving *your* request when *you* are appealing the denial for urgent care. (If *your* appeal concerns urgent care, *you* may be able to have the internal appeal and external reviews take place at the same time).
  - 10 days from receipt of request for appeals of denials of non-urgent care *you* have not yet received.
  - 30 days from receipt of request for appeals of denials of services *you* have already received (post-service denials).
  - No extensions of the maximum time limits will be permitted without *your* consent.

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

Cost and Minimums for Appeals: There is no cost to *you* to file an appeal and there is no minimum amount required to be in dispute.

Defined terms: Any terms appearing in *italics* are defined in the Definitions section.

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

***Your* rights to file an appeal of denial of health benefits:** *You* or *your authorized representative*, such as *your healthcare provider*, may file the appeal for *you*, verbally or in writing, either by mail or by facsimile (fax). For an urgent request, *you* may also file an appeal by telephone:

Buckeye Community Health Plan at the Appeals Unit, 4349 Easton Way, Suite 400, Columbus, OH, 43219, by telephone at 1-877-687-1189 (TTY/TDD 1-877-941-9236), by fax at 1-866-258-4102 or Ambetter.BuckeyeHealthPlan.com.

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

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

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

Time Limits for filing an internal claim or appeal: *You* must file the internal appeal within 180 days of the receipt of the notice of claim denial (an *adverse benefit determination*). Failure to file within this time limit may result in the company's declining to consider the appeal.

Time Limits for an External Appeal: *You* have 180 days to file for an *external review* after receipt of the plan's *final adverse benefit determination*.

***Your* Rights to a Full and Fair Review**. The plan must allow *you* to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.

- The plan must provide *you*, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal *adverse benefit determination* is required to give *you* a reasonable opportunity to respond prior to that date; and
- The adverse determination must be written in a manner understood by *you*, or if applicable, *your authorized representative*, and must include all of the following:

  The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);

  Information sufficient to identify the claim involved, including the date of service, the *healthcare provider*;

  A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; and

  Your right to an independent internal review.

- As a general matter, the plan may deny claims at any point in the administrative process on the basis that it does not have *sufficient information*; such a decision; however, will allow *you* to advance to the next stage of the claims process.

Other Resources to help *you*

Department of Insurance: For questions about *your* rights or for assistance *you* may also contact the Consumer Services Division at the Ohio Department of Insurance 1-800-686-1526.

Language services are available from the health benefit plan and from The Ohio Department of Insurance.

***Your* rights to appeal and the instructions for filing an appeal are described in the "*Your* rights to file an appeal of denial of health benefits" provision above. *You* can also contact *us* directly by telephone at 1-877-687-1189 (TTY/TDD 1-877-941-9236) or visit *our* website Ambetter.BuckeyeHealthPlan.com.**

INTERNAL CLAIMS AND APPEALS

Non-urgent, Pre-Service claim denial

For a non-urgent *pre-service claim*, the plan will notify *you* of its decision as soon as possible but no later than 10 days from the receipt of the request.

If the plan needs more time, it will contact *you*, in writing, telling *you* the reasons why it needs more time and the date when it expects to have a decision for *you*, which should be no later than 10 days.

If the plan needs additional information from *you* before it can make its decision, it will provide a notice to *you*, describing the information needed. If *you* do not provide the additional information, the plan can deny *your* claim. In which case, *you* may file an appeal.

The plan must make its decision within 10 days from the receipt of the request.

Urgent Pre-service Care claim denial

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

If the claim for benefits is one *involving urgent care*, *we* will notify *you* of *our* decision as soon as possible, but no later than 48 hours after *we* receive *your* claim provided *you* have given *us* information sufficient to make a decision.

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

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

Simultaneous *urgent claim and expedited* internal review:

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

Simultaneous urgent claim, expedited internal review and external review:

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

(1) *You* have filed a request for an expedited internal review; and

(2) After a *final adverse benefit determination*, either of the following applies:

(a) *Your* treating *physician* certifies that the *adverse benefit determination* involves a medical condition that could seriously jeopardize the life or health of *you*, or would jeopardize *your* ability to regain maximum function, if treated after the time frame of a standard external review; or

(b) The *final adverse benefit determination* concerns an admission, availability of care, continued stay, or healthcare service for which *you* received *emergency services*, but have not yet been discharged from a facility.

Concurrent Care Decisions

For concurrent review determinations, *we* shall make the determination within one business day after obtaining all necessary information from *you*. Concurrent review determinations, are determinations made for an ongoing treatment plan or course of treatment that is continuing over a period of time. *We* will notify *you* if *we* decided to reduce or terminate the treatment. Additionally, concurrent review would be utilized if *you* wish to request to extend an approved treatment beyond what has already been approved.

In the case of a determination to authorize an extended stay or additional health care services, *we* will notify the *provider* or health care facility rendering the health care service by telephone or facsimile within one business day after making the authorization request.

In the case of an adverse determination, *we* will notify the *provider* or health care facility rendering the health care service by telephone within one business day after making the adverse determination, and provide written or electronic confirmation to *you* and the provider or health care facility within one business day after the telephone notification. *Your* health care services will be continued, with standard *copayments* and *deductibles*, if applicable, until *you* have been notified of the determination.

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* as 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 the plan 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 the plan 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 48 hours after receipt.

Retrospective Review: Post-service appeal of a claim denial
If *your* appeal is for a *post-service claim denial*, *we* will notify *you* of *our* decision as soon as possible but no later than 30 days of receipt of the request.

EXTERNAL REVIEW

Right to External Review
Under certain circumstances, *you* have a right to request an external review of *our* adverse benefit decision by an *independent review organization* or by the superintendent of insurance, or both.

If *you* have filed internal claims and appeals according with the procedures of this plan, and the plan has denied or refused to change its decision, or if the plan has failed, because of its actions or its failure to act, to provide *you* with a *final determination* of *your* appeal within the time permitted, or if the plan waives, in writing, the requirement to exhaust the internal claims and appeals procedures, *you* may make a request for an *external revie*w of an *adverse benefit determination*.

All requests for an *external review* must be made within 180 days of the date of the notice of the plan's *final adverse benefit determination*. Standard requests for an external review must be provided in writing; requests for expedited external reviews, including experimental/investigational, may be submitted orally or electronically. When an oral or electronic request for review is made, written confirmation of the request must be submitted to the plan no later than 5 days after the initial request was made.

***You* may file the request for an *external review* by contacting the plan**

Buckeye Community Health Plan at the Appeals Unit, 4349 Easton Way, Suite 400, Columbus, OH, 43219, by telephone at 1-877-687-1189 (TTY/TDD 1-877-941-9236), by fax at 1-866-258-4102 or Ambetter.BuckeyeHealthPlan.com.

Non-urgent request for an external review

Unless the request is for an expedited external review, the plan will initiate an external review within 5 days after it receives *your* written request if *your* request is complete. The plan will provide *you* with notice that it has initiated the external review that includes:

(a) The name and contact information for the assigned *independent review organization* or the superintendent of insurance, as applicable, for the purpose of submitting additional information; and

(b) Except for when an expedited request is made, a statement that *you* may, with 10 business days after the date of receipt of the notice, submit, in writing, additional information for either the *independent review organization* or the superintendent of insurance to consider when conducting the external review.

If *your* request is not complete, the plan will notify *you* in writing and include information about what is needed to make the request complete.

If the plan denies *your* request for an external review on the basis that the *adverse benefit determination* is not eligible for an external review, the plan will notify *you*, in writing, the reasons for the denial and that *you* have a right to appeal the decision to the superintendent of insurance.

If the plan denies *your* request for an *external review* because *you* have failed to exhaust the Internal Claims and Appeals Procedure, *you* may request a written explanation, which the plan will provide to *you* within 10 days of receipt of *your* request, explaining the specific reasons for its assertion that *you* were not eligible for an *external review* because *you* did not comply with the required procedures.

Request for external review to the Department of Insurance: If the plan denies *your* request for an *external review*, *you* may file a request for the superintendent of insurance to review the plan's decision by contacting Consumer Services Division at 1-800-686-1526 between 8:00 a.m. and 5:00 p.m., eastern standard time or by sending a written request addressed to: Consumer Services, The Ohio Department of Insurance, 50 West Town St., Suite 300, Columbus, Ohio 43215. Information about external reviews is also available on the Department's website: www.insurance.ohio.gov.

If the DOI upholds the plan's decision: If *you* file a request for an external review with the DOI, and if the DOI upholds the plan's decision to deny the *external review* because *you* did not follow the plan's internal claims and appeals procedures, *you* must resubmit *your* appeal according to the plan's internal claims and appeals procedures within 10 days of the date of *your* receipt of the superintendent's decision. The clock will begin running on all of the required time periods described in the internal claims and appeals procedures when *you* receive this notice from the superintendent.

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

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

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

(1) Standard healthcare services have not been effective in improving *your* condition;

(2) Standard healthcare services are not medically appropriate for *you*; or

(3) There is no available standard healthcare service covered by the health plan issuer that is more beneficial than requested healthcare service.

The request for an expedited external review under this provision may be requested orally or electronically. For Expedited/Urgent requests, *your healthcare provider* can orally make the request on *your* behalf.

Independent Review Organization: An *external review* is conducted by an *independent review organization* (*IRO*) selected on a random basis as determined in accordance with Ohio law. The *IRO* will provide *you* with a written notice of its decision to either uphold or reverse the plan's *adverse benefit determination* within 30 days of receipt of a *standard external review* (not urgent).

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

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

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

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

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

Review by the Department of Insurance: If the plan has made an *adverse benefit determination* based on a contractual issue (e.g., whether a service or services are covered under *your contract* of insurance), *you* may request an external review by the department of insurance.

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

General Provisions

Entire Contract
This *contract*, with the application, and *Schedule of Benefits* is the entire contract between *you* and *us*. No agent may:

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

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

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

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

Repayment for Fraud, Misrepresentation, or False Information
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*.

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

Hold Harmless
Buckeye Community Health Plan is not a member of any guaranty fund, and in the event that *we* become insolvent, *member* is protected only to the extent that the hold harmless provision under 1751.13 applies to those healthcare services rendered.

In addition, in the event *we* become insolvent, the *member* may be financially responsible for healthcare services rendered by a *provider* or healthcare facility that is not under contract with *us*. However, the *member* is protected only to the extent that the hold harmless provision under 1751.13 applies to those healthcare services rendered.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Buckeye Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Buckeye Health Plan 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 1-877-687-1189 (TTY/TDD 1-877-941-9236)。
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Buckeye Health Plan 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 1-877-687-1189 (TTY/TDD 1-877-941-9236) an.
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Buckeye Health Plan، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Pennsylvania Dutch:	Vann du, adda ebbah's du am helfa bisht, ennichi questions hott veyyich Ambetter from Buckeye Health Plan, 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 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Buckeye Health Plan вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-877-687-1189 (TTY/TDD 1-877-941-9236).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Buckeye Health Plan, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Buckeye Health Plan, 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 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Cushite:	Yoo sii ykn namaa gargaaraa jirtuu wa'ee Ambetter from Buckeye Health Plan gaaffi qabaatan ta'ee gargaarsaa fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana wajiin dubadhuu, 1-877-687-1189 irra bilbilli (TTY/TDD 1-877-941-9236).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Buckeye Health Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-687-1189 (TTY/TDD 1-877-941-9236)로 전화하십시오.
Italian:	Se lei, o una persona che lei sta aiutando, avesse domande su Ambetter from Buckeye Health Plan, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l'1-877-687-1189 (TTY/TDD 1-877-941-9236).
Japanese:	Ambetter from Buckeye Health Plan について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-877-687-1189 (TTY/TDD 1-877-941-9236)までお電話ください。
Dutch:	Als u of iemand die u helpt vragen heeft over Ambetter from Buckeye Health Plan, hebt u recht op gratis hulp en informatie in uw taal. Bel 1-877-687-1189 (TTY/TDD (teksttelefoon) 1-877-941-9236) om met een tolk te spreken.
Ukrainian:	В разі виникнення у вас або особи, якій ви допомагаєте, будь-яких запитань щодо програми страхування Ambetter from Buckeye Health Plan ви маєте право отримати безкоштовну допомогу та інформацію на своїй рідній мові. Щоб поговорити з перекладачем, зателефонуйте за номером 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Romanian:	Dacă dvs. sau o persoană pe care o asistați are întrebări despre Ambetter from Buckeye Health Plan, aveți dreptul să obțineți asistență și informații în limba dvs. în mod gratuit. Pentru a vorbi cu un interpret, apelați 1-877-687-1189 (TTY/TDD 1-877-941-9236).

Statement of Non-Discrimination

Ambetter from Buckeye Health Plan 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 Buckeye Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Buckeye Health Plan:

- 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 Buckeye Health Plan at 1-877-687-1189 (TTY/TDD 1-877-941-9236).

If you believe that Ambetter from Buckeye Health Plan 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: Buckeye Health Plan at the Appeals Unit, 4349 Easton Way, Suite 400, Columbus, OH 43219, 1-877-687-1189 (TTY/TDD 1-877-941-9236), Fax 1-866-719-5404. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from Buckeye Health Plan 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*.